IMPROVING STATE PROGRAMS FOR PREGNANT WOMEN AND CHILDREN: CONFERENCE PROCEEDINGS

NATIONAL GOVERNORS' ASSOCIATION

STATE POLICY REPORTS

HEALTH STUDIES

March 29-31, 1989
San Antonio, Texas

The National Governors' Association, founded in 1908 as the National Governors' Conference, is the instrument through which the nation's Governors collectively influence the development and implementation of national policy and apply creative leadership to state issues. The association's members are the Governors of the fifty states, the commonwealths of the Northern Mariana Islands and Puerto Rico, and the territories of American Samoa, Guam, and the Virgin Islands. The association has seven standing committees on major issues: Agriculture and Rural Development; Economic Development and Technological Innovation; Energy and Environment; Human Resources; International Trade and Foreign Relations; Justice and Public Safety; and Transportation, Commerce, and Communications. Subcommittees and task forces that focus on principal concerns of the Governors operate within this framework.

The association works closely with the administration and Congress on state-federal policy issues through its offices in the Hall of the States in Washington, D.C. The association serves as a vehicle for sharing knowledge of innovative programs among the states and provides technical assistance and consultant services to Governors on a wide range of management and policy issues.

The Center for Policy Research is the research and development arm of NGA. The center is a vehicle for sharing knowledge about innovative state activities, exploring the impact of federal initiatives on state government, and providing technical assistance to states. The center works in a number of policy fields, including agriculture, economic development, education, environment, health, social services, training and employment, trade, and transportation.

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Edited by Janine Breyel

Health Policy Department
Human Resources Policy Studies Division
Center for Policy Research

National Governors' Association

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ACKNOWLEDGEMENTS

The National Governors' Association (NGA) acknowledges the generous financial assistance provided by the U.S. Public Health Service to support our highly successful conference on "Improving State Programs for Pregnant Women and Children."

This conference proceedings is the seventh report in the series *Facilitating Improvement of State Programs for Pregnant Women and Children*. With a primary goal of highlighting innovative, collaborative state efforts to implement improved perinatal programs, this project is supported by the Bureau of Maternal and Child Health and Resources Development (BMCHRD) and the Bureau of Health Care Delivery and Assistance (BHCDA), Health Resources and Services Administration (HRSA), Public Health Service, U.S. Department of Health and Human Services. For their assistance in framing both the research agenda of the project and many of the issues addressed at the conference, sincere appreciation is extended to Ann Koontz (BMCHRD) and Joan Holloway (BHCDA). For additional assistance in project development, gratitude is also extended to Ron Carlson, Associate Administrator for Planning, Evaluation, and Legislation at HRSA.

This publication represents the collaborative efforts of a number of people. NGA is especially grateful to conference participants for their substantial contributions both at the conference and on drafts of the proceedings.

This publication was edited by Janine Breyel, senior research assistant at NGA, based on transcripts of the speakers' presentations. Ian Hill, NGA's project director of *Facilitating Improvement of State Programs for Pregnant Women and Children*, reviewed and commented on various drafts of the proceedings. Special thanks are also extended to John Luehrs for his critical guidance over the course of this publication's development, Barbara Tymann for her skillful preparation of the manuscript, and Mark Miller for his careful and professional editorial assistance.

FOREWORD

April 1, 1987, marked the initial effective date of what is, perhaps, the most important single piece of health care legislation affecting low-income pregnant women and children passed during the 1980s. The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) provided states with the flexibility they sought to sever the historical link between Medicaid programs and Aid to Families with Dependent Children programs in order to raise income eligibility thresholds for pregnant women and young children to the federal poverty level.

Upon the two-year anniversary of this date, it was appropriate to take stock of what had resulted since passage of OBRA-86 – to assess how far this nation's public perinatal programs had come in combating infant mortality and improving the health of mothers and infants. The National Governors' Association believed it would be valuable to bring together state and federal officials to discuss the progress that had been made, to share information on innovative programs and policy strategies, and to begin formulating a plan for the work that still remained.

Over a three-day period – March 29-31, 1989 – approximately 300 individuals convened in San Antonio, Texas to accomplish these important goals. Attendees represented state and federal programs including Maternal and Child Health, Medicaid, Community and Migrant Health Centers, and WIC, as well as consumer and provider associations, universities, and advocacy groups. This publication summarizes that meeting and attempts to capture the critical insights exchanged by conference participants.

This conference represented the capping event of the initial two-year phase of an NGA project titled *Facilitating Improvement of State Programs for Pregnant Women and Children*. In early 1987, the Health Programs unit of the NGA's Center for Policy Research approached the Health Resources and Services Administration (HRSA) with a proposal to track state efforts to design and implement more effective public perinatal programs. Of paramount interest, the proposal focused on identifying and highlighting opportunities where various state and federal agencies could collaboratively formulate comprehensive, creative initiatives. Under this spirit of cooperation, two offices within HRSA – the Bureau of Maternal and Child Health and Resources Development and the Bureau of Health Care Delivery and Assistance – extended the financial resources needed to study, in depth, the barriers facing states and the federal government, to analyze the facets of successful program approaches, and to report on innovative strategies being employed by states.

The NGA project set about the task of studying the significant potential offered by OBRA-86 and the broad implications the act held for state Medicaid and Maternal and Child Health programs. While OBRA-86 opened a new door for states through which financial access to health care could be extended to thousands of families, it also represented only a first step toward the goal of improving birth outcomes and maternal and child health status. By itself, OBRA-86 represented a change in eligibility rules. In order to truly impact health status, states, in tandem

with the federal government, needed to also address a broad range of issues and problems within existing public program structures:

- In order to enroll potentially eligible women and children, states needed to simplify, streamline, and make more accessible their complex and onerous eligibility systems.
- In order to make persons aware of the availability of this new coverage, public awareness needed to be raised through outreach and education efforts.
- In order to ensure that women seeking care could find it, states needed to confront multiple complex problems fueling a severe shortage of obstetrical providers.
- If women and children were to be served appropriately, states would need to directly focus on the quality of care provided under Medicaid and develop strategies to improve the scope and comprehensiveness of perinatal services.
- To assess the impact of various initiatives, states would have to improve their capacity to measure and evaluate the effectiveness of program changes.

Indeed, at the two-year anniversary of OBRA-86, it had already become clear that states had not simply expanded eligibility. In nearly every state, the act had instead served as a catalyst for important program reforms in all the policy areas described above.

This publication presents detailed information regarding these sweeping reforms by summarizing the presentations of state and federal officials participating in the meeting. Initiatives are organized into four broad sections – "Removing Barriers to Access," "Enhancing the Delivery of Care," "Building Integrated Programs,"and "Charting a Course for the Future."

The Health Programs staff at NGA wish to congratulate all conference attendees for their engaging and active participation in this important meeting. We hope that this document makes it possible for those persons not in attendance to learn from the exciting dialogue that occurred in San Antonio.

Ian T. Hill
Project Director

"Today, the challenge of reducing infant mortality is not as much a question of medicine and technology as it is a question of our political will to save our children – our ability to organize public priorities, budgets, turf, and mobilize personnel to reach out and save our children. We've seen this will demonstrated in some very exciting ways in the last several years in states across this nation. . . in ways that have helped move forward an enlightened agenda of health care for mothers and children. . . .

"Research helps us to target the market that we need to reach out to. Knowing more about the people we serve, their diverse needs, what programs work and which ones don't, should be our blueprint for enlarging the scope and diversity of services available to poor pregnant women and children. But above all else, I think the critical ingredient is coordination. Better coordination is absolutely vital when we think of how we reach those who are in need and when we think about the variety of resources we have available. . . .

"We have a challenge, in setting forth an agenda for local human service directors, that there be a clear understanding that health care for women and children is a stunning priority, not a stack of paperwork. If we do right in this arena, we have a profound impact on all that happens later in life. And if we fail, we make every next step more difficult. . . .

"Every day that we balk at extending eligibility; every day that we protect our own present system of delivering services for fear of change; every day that we resist the frustration and aggravation that comes with trying to coordinate and collaborate with new partners in new ways; every day that we do these things, there are young people who suffer the consequences. Unless we move forth on these issues, and see them as part of a continuum of service to women and children that reaches from before those babies are conceived until they have grown to be prepared parents themselves, we fall short of meeting our responsibility in this country today."

Governor Richard Celeste, Ohio
Chairman, National Governors' Association Committee on Human Resources
March 31, 1989

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San Antonio, Texas
March 29-31, 1989

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REMOVING BARRIERS TO ACCESS

"Access is more than financial resources. I want to mention a few carefully chosen 'A' words, besides 'affordability,' that are also components of access. 'Awareness' is the recognition of the importance of and need for prenatal care and how to obtain it. I am speaking of awareness on the part of the women that we want to come in for care in a timely fashion as well as the general public.

"'Availability' is the physical presence of providers and care facilities within a reasonable distance of women who need care. This is a concern in both rural areas and inner cities.

"'Acceptability' is the favorable receipt of services offered; a recognition of cultural diversity and how well or how poorly we're meeting various people's needs; and the recognition of the central role of the family.

"'Appropriateness' is the efficacy and quality of care measured against the patient's needs. We must be careful not to spend all of our time talking about reimbursement levels and eligibility and not also talk about quality.

"The last 'A' word is 'accountability'—responsibility for follow-up and follow-through and an increasing emphasis on the fact that if one is using public resources, whether federal or state, then there is an obligation by program officials and providers to return information about how those funds are being used and what improvements are occurring as a result of their use."

Vince Hutchins, Deputy Director
Bureau of Maternal and Child Health and
Resources Development
U.S. Public Health Service
March 29, 1989

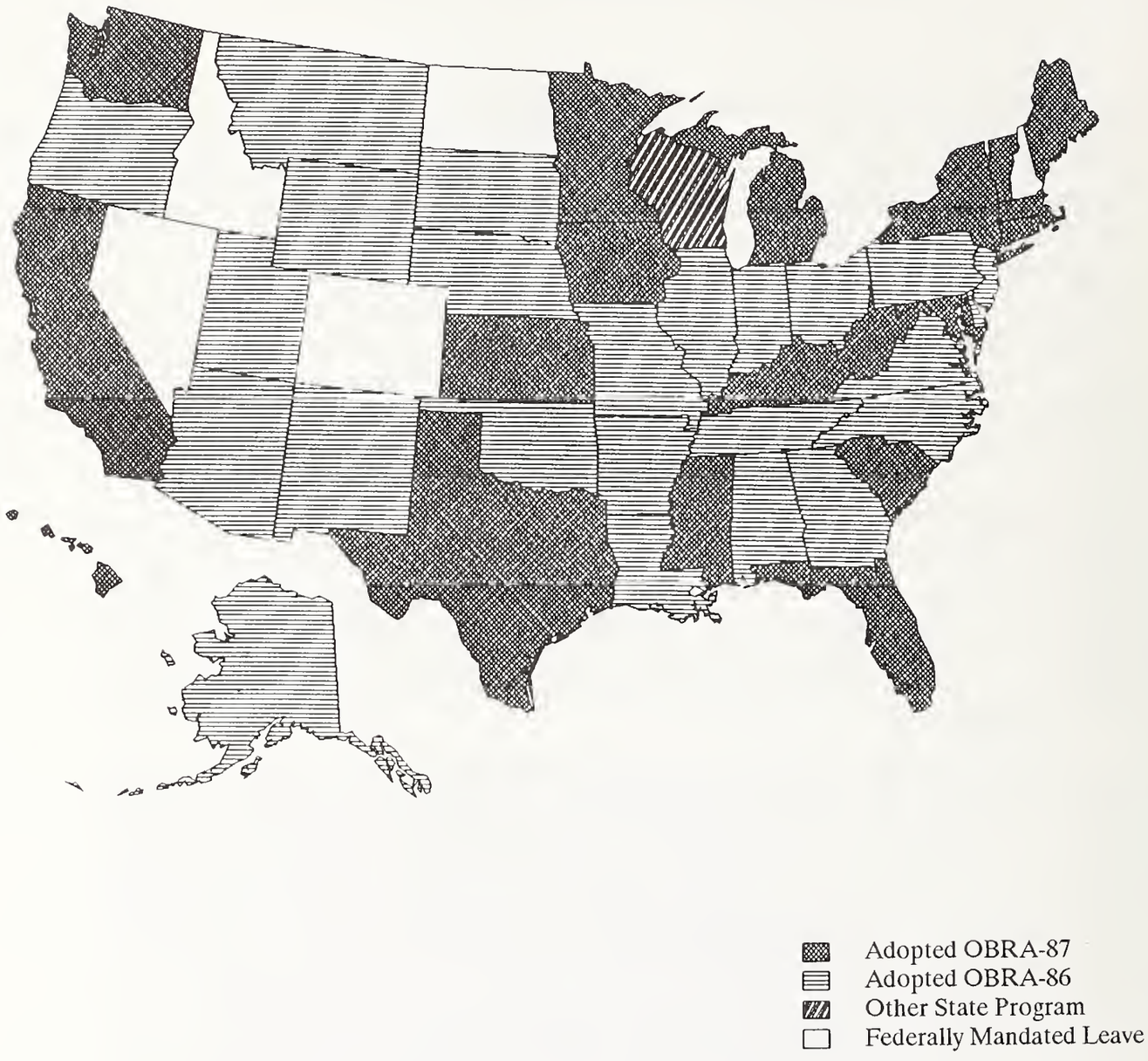
1

Streamlining Eligibility Systems

Encouraging steps to expand eligibility for pregnant women and children have been taken by states across the nation. The Omnibus Budget Reconciliation Act of 1986 (OBRA) afforded states the opportunity to raise income eligibility thresholds for pregnant women and children up to age five to the federal poverty level. OBRA-87 legislation gave states the flexibility to raise thresholds even higher – to 185 percent of the federal poverty level. Additionally, states could phase in coverage of children up to age eight. By March 1989 all but seven states adopted some form of expansion of eligibility for pregnant women and children up to or above the federal poverty level. Of the forty-four that have expanded, twelve have adopted the OBRA-87 flexibility to go above the federal poverty level to as high as 185 percent of poverty. All but fourteen states that have adopted expanded coverage are now covering children over the age of one. Nine of those have boosted coverage all the way up to age five, while twenty-two are phasing in coverage of children one year at a time.[1] Thirty-four of the forty-four states have dropped all resource tests in their determination process. And thirty-eight of the forty-four have adopted the continuous eligibility provision guaranteeing eligibility throughout the pregnancy. Twenty states now have presumptive eligibility programs. (See Figure 1 and Table 1.) However, even with these expansions states are still faced with many challenges regarding eligibility.

The first question any state faces after adopting expanded eligibility is: How will we succeed in enrolling the thousands of women who have become potentially eligible by raising our income thresholds? A growing body of research has made it clear that eligibility systems for Medicaid are themselves serving to inhibit many women from enrolling in the program. It has become obvious that while OBRA-86 severed the income linkage between AFDC and Medicaid, it did not separate the processes through which persons become eligible for the two programs. The Medicaid eligibility process is still intimately linked to the AFDC eligibility process. Problems such as the traditional welfare stigma attached to applying for aid can inhibit many women who might need or want only prenatal care. Having the first point of contact between a pregnant woman and an eligibility worker occur in a county welfare office, rather than a provider site where prenatal care is delivered, also serves as a barrier to the program. The application, as long as forty-five pages in some states, is often incredibly complex and requires intensive verification. Finally, the slow processing of applications can delay the eligibility determination. States have, by law, up to forty-five days to make a determination. Most states have traditionally used that much time, if not more.

Figure 1
States Broadening Medicaid Eligibility
Coverage of Pregnant Women and Children Up To/Above Poverty
July 1989



SOURCE: National Governors' Association, 1989.

Table 1
OBRA-86 Summary Status: Coverage Options for Pregnant Women and Children

	Adopted/ Percent Poverty	*Age Coverage*		*Dropped Assets Test*	*Continuous Eligiblility*	*Presumptive Eligiblility*	*Effective Date*
		1	*2-6*				
Alabama	100	■		■	■	■	7/88
Alaska	100		■	■	■		1/89
Arizona	100		■	■	■		1/88
Arkansas	100		■	■	■	■	4/87
California	185	■					7/89
Colorado							
Connecticut	185	■		■	■		4/88
Delaware	100		■	■	■		1/88
D. of Columbia	100		■	■	■		4/87
Florida	100		■	■	■	■	10/87
Georgia	100		■	■	■		1/89
Hawaii	100	■		■	■	■	1/89
Idaho	67	■		■	■	■	1/89
Illinois	100	■					7/88
Indiana	50	■		■	■	■	7/88
Iowa	150		■				1/89
Kansas	100		■	■			7/88
Kentucky	125		■		■		10/87
Louisiana	100		■	■	■	■	1/89
Maine	185		■	■		■	10/88
Maryland	100		■	■	■	■	7/87
Massachusetts	185		■	■	■	■	7/87
Michigan	185		■	■	■		1/88
Minnesota	185	■		■	■		7/88
Mississippi	185		■		■		10/87
Missouri	100		■		■		1/88
Montana							
Nebraska	100		■	■	■	■	7/88
Nevada							
New Hampshire							
New Jersey	100		■	■	■	■	7/87
New Mexico	100		■		■	■	1/88
New York						■	undecided
North Carolina	100		■	■	■	■	10/87
North Dakota							
Ohio	100	■		■	■		1/89
Oklahoma	100		■	■	■		1/88
Oregon	100		■	■	■		11/87
Pennsylvania	100		■	■		■	4/88
Rhode Island	185		■	■	■		4/87
South Carolina	100	■		■	■		10/87
South Dakota	100	■		■	■		7/88
Tennessee	100		■	■	■	■	7/87
Texas	100		■		■	■	9/88
Utah	100	■		■	■	■	1/89
Vermont	185		■		■		10/87
Virginia	100	■		■	■		7/88
Washington	90		■		■		7/87
West Virginia	150		■	■	■		7/87
Wisconsin						■	4/88
Wyoming	100	■		■	■		10/88
TOTAL	44	14	30	34	38	20	

SOURCE: National Governors' Association, January 1989.

All this has led to a situation whereby an enormous percentage of women applying for assistance are denied not because they have excess income, nor because they have excess resources. Rather, they are denied because they fall into a category called "Does not comply with procedural requirements." Federal AFDC data consistently show that 60 percent of all AFDC application denials are in this category. This large percentage represents a "black hole" since little is known about those denials. Not complying with procedural requirements could mean that women have missed appointments with intake workers, or that income verification was not sent in, or that the right number of bank statements, pay stubs, birth certificates, etc. were not collected or submitted. What is known, on the other hand, is that the majority of the people are being denied eligibility because they simply cannot complete the process.

States have put strategies in place over the last two years aimed at addressing some of these barriers. The Wisconsin Medicaid program implemented the very promising, very complex option of presumptive eligibility. Oregon decided on an alternative strategy of shortening its application form and implementing expedited eligibility. Florida not only picked up the presumptive eligibility option, but also outposted eligibility workers at prenatal care provider sites throughout the state. All three states, using different strategies, are succeeding in streamlining the eligibility process.

Presumptive Eligibility in Wisconsin

In 1987, the Medicaid program in Wisconsin was mandated to implement presumptive eligibility by the state legislature. Medicaid officials took a dim view of the option at first, thinking it would make an already complex eligibility system even more complicated. However, over time the state has experienced the benefits of a presumptive eligibility system.

Wisconsin has found that the presumptive eligibility system has the following advantages:

- **A captive audience at the provider site.** Pregnant women who are not currently enrolled in the Medicaid program are already receiving services from qualified providers.
- **A verbal declaration of income.** Simply asking clients about their income and marital status is much easier than requiring clients to bring in a stack of documentation.
- **Providers held harmless for period of presumptive eligibility.** Providers know that if they bill for services provided to a patient with a valid presumptive eligibility card, their claims will be paid whether or not the woman is later found ineligible.

Wisconsin has taken several steps to help ensure the success of the new system. The first step was to conduct training workshops to notify providers of the program. Working closely with providers has proven to be one key to making presumptive eligibility work in the state. By letting the providers know what is in it for them—getting paid regardless of the client's ultimate eligibility determination

and being able to provide care immediately–the state has been able to build a network of providers interested in seeing and treating these women.

OBRA-86 contains specific language regarding which providers can be "qualified" to make presumptive eligibility determinations. In order to receive such status and be permitted to grant presumptive eligibility, a provider must "1) be eligible for Medicaid payments; 2) provide outpatient hospital services, rural health services, or clinic services; 3) be determined by the state agency to be capable of making presumptive eligibility determinations; and 4) either receive funds under the Migrant Health Centers, Community Health Centers, or Maternal and Child Health block grant programs; participate in the Special Supplemental Food Program for Women, Infants, and Children (WIC) or the Commodity Supplemental Food Programs; or participate in a state perinatal program." Although this language appears to restrict the providers who must be qualified to administer presumptive eligibility, the final phrase–"or participate in a state perinatal program"–does provide states with significant flexibility. Wisconsin took advantage of this language to define "state perinatal program" very broadly, allowing the state to expand participation to a larger provider population.

An additional advantage to setting up a presumptive eligibility system, as opposed to any other system to streamline eligibility, was the relatively small cost involved. In Wisconsin, system changes cost less than $10,000.

In March 1989 the state found that 98 percent of the presumptively eligible women were ultimately granted full Medicaid eligibility. The state also found that the remaining 2 percent were usually denied because of excess assets. Due to the fact that Wisconsin is planning to waive its resource test in the future, officials expect the conversion to formal eligibility to climb even closer to 100 percent.

Expedited Eligibility Determinations in Oregon

In Oregon a very different, but equally effective, system was set up to increase access to prenatal care in the state's Medicaid program. The state had raised its income threshold in 1987, yet had experienced very little change in enrollment. A task force was formed to study how access could be streamlined. Representatives from the social services' field staff, central office staff, state MCH agency, urban and rural health departments, Oregon Medical Association, and Office of Rural Health recommended that the state simplify the Medicaid eligibility process. Acting on this recommendation, the state drastically shortened its application forms and reduced verification requirements. They were able to make these changes mainly because the resource test was also dropped. The state also went a step further and decided to expedite the eligibility process for pregnant women by requiring that county social service offices make formal determinations in twenty-four hours. The state believed this would ensure early entry into its newly expanded program.

Making a determination in twenty-four hours was an ambitious goal, but how could it be accomplished? The agency administrator realized that instead of focusing on systems changes entirely, some philosophical discussion also would have to take place if the expanded program was to be a success. Such discussion between state and local officials had been lacking after the original expansion: While the

eligibility workers were aware of the new changes, they were not sensitized to the reasons for these changes. Overcoming this obstacle was one key to the success of expedited eligibility. The agency administrator also informed the field officials that in order to meet the twenty-four-hour deadline, workers were to issue a Medicaid card to those women who appeared eligible, with the understanding that the follow-up verification of income and other items would be collected later.

To simplify the process and increase the chances for success, several other steps were taken by the state. By revising existing intake screening forms (e.g., adding the question "Are you pregnant?"), the state did not have to create another application form. The state also decided to define "pregnancy-related coverage" as full-service coverage, since it was felt that any and all conditions have the potential to affect pregnancy. By defining "pregnancy-related" as such, a major change in the system was avoided (i.e., women would not have any incentive to constantly switch between this program and the state's Medically Needy program).[2]

Early evidence demonstrates that Oregon's approach is succeeding in enrolling significant numbers of pregnant women into Medicaid. Between July 1988 and January 1989, enrollment jumped from 1,100 women to 4,000 – a nearly 400 percent increase in just six months. Officials' enthusiasm for the strategy has been tempered a bit by potential quality control problems. Because of the short implementation period, there has been some confusion in the field. For example, in some areas of Oregon the field staff, reacting enthusiastically to this new-found freedom, appeared to do little verification. To help correct this, the state is asking health department providers who refer women to the eligibility offices to ask those women to bring with them documentation of pregnancy and verification of income.[3]

Oregon learned that access to prenatal care can be increased without presumptive eligibility. However, other lessons were learned as well, including:

- Providers must be involved in developing solutions;
- Monitoring mechanisms must be set up to decrease quality control risks; and
- Preparation must be made for the budget impact caused by all the new eligible women.

Outposting of Eligibility Workers in Florida

In Florida, several strategies have been used to streamline the eligibility process. The state not only adopted presumptive eligibility for pregnant women, but also shortened its application form to one page and outstationed eligibility workers to facilities where women receive prenatal care. As of December 1988 there were 304 eligibility specialists working in 211 separate sites. These facilities include hospitals, health departments, and federal primary care centers.

To implement the new policies, the state executive branch mandated that local indigent health care teams be established in each of the state's eleven regions. The teams consisted of representatives from public health, economic services (which makes eligibility determinations), Medicaid, and the Children with Special Health Care Needs program (which has a high-risk pregnancy program). Staff from

these four programs were mandated to get together and discuss how outstationing, training for presumptive eligibility, and billing through Medicaid would be accomplished. This was one key to successful implementation.

Another key to the state's success was the creation of a state-level technical and consultation team. The team visits districts and reviews policies and programs in the field to make sure they are implemented as intended by the state. Florida has found that despite information letters, notices, data reports, etc., there is no substitute for actual site visits to assure that policies are operating as intended and that inter-programmatic cooperation is taking place.

As was the case in Oregon, Florida found that philosophical discussions helped ensure the program's success. Statewide conferences were held for the benefit of eligibility specialists. At these conferences, the eligibility workers heard how critical they were to solving the problem of infant mortality.

Yet even with the steps taken to implement the program successfully, some problems were not anticipated. One problem related to the specialization of eligibility workers. Medicaid specialists working at the hospital would still have to send clients to the social services offices when these clients were potentially eligible for other programs, such as AFDC. In some cases, the clients were being shuffled back and forth between the two sites – the same problem that outposting eligibility workers was supposed to solve. Another problem not anticipated by the state was the high turnover rate of eligibility workers because of low pay and inadequate training. Similarly, automation of the eligiblity system has been a problem. If the system can be automated over the next couple of years, as is the hope in Florida, many tasks now requiring specialization can be completed automatically.

The state has been forced to address the effects of outposting eligibility workers on workloads. Even though clients are being seen at health care sites, ever-increasing numbers of people are still coming into local social services offices. Because of this, eligibility workers cannot be taken out of these offices and outstationed at other facilities. The state executive branch has dealt with this problem by successfully persuading the legislature to establish funding for eligibility workers.

By outposting workers, Florida has learned some valuable lessons in working with health care facilities, especially hospitals. The state has learned how advantageous it can be to penetrate the management structure of the hospital. Eligibility specialists can be located near admitting clerks, which makes it much easier for clients to be immediately referred to the eligibility workers upon entering the hospital rather than after they are treated. The state also has been able to persuade management in some facilities to provide incentives to the eligibility workers outposted there. Such benefits as free parking and employee discounts (in hospital cafeterias and gift shops) can do wonders for morale. This can also help address the problem of high turnover (among eligibility workers).

Through presumptive eligibility, shortened application forms, and outposting of eligibility workers, the state has begun to see improvements in access. This is evidenced by the 31 percent increase in services delivered in one year. Also, the number of clients has risen: The average monthly caseload was up 8 percent in 1988; this year it is up 15 percent. Monitoring, reports, site visits, and district coordinated

teams are all viewed as critical to making the new policy a success. By the same token, attitude, understanding, and communication are crucial to streamlining the eligibility process.

Conclusion

When OBRA-86 and OBRA-87 provided the opportunity to raise income eligibility thresholds, states quickly realized that raising thresholds alone did little to increase access to prenatal care. States such as Wisconsin, Oregon, and Florida began putting into place strategies aimed at addressing other barriers in their Medicaid eligibility processes. These states have found that adopting a presumptive eligibility system, expediting the eligibility process, shortening the application form, outstationing eligibility workers, or a combination of these strategies can be successful in improving access to and enrollment in newly expanded state perinatal programs. As states gain more experience in streamlining their eligibility processes, they will see an increase in access to prenatal care and, ultimately, the goal of lowering infant mortality will be facilitated.

Panelists:

Sarah Kruger
Maternal and Child Health Specialist
Wisconsin Medicaid

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2

Targeting Outreach Effectively

As states continue to expand eligibility for pregnant women, the issue of outreach must be addressed. States are confronted with the problem of enrolling the thousands of women made eligible by raising income thresholds up to, or above, the poverty level. But how can outreach be targeted effectively to women who may not enter prenatal care early or continue in care for various reasons?

The term outreach is itself problematic. What is outreach? To some, outreach refers to a process that recruits women into care – a system that finds eligible women who are in need of services, but are not receiving them. Others refer to outreach as a service similar to care coordination – providing support to ensure that women continue in care once they enter into the prenatal system. For purposes of this discussion, outreach is considered the process of finding women who need care, informing them of the importance of early and continuous prenatal care, and enrolling them.

Another problem with outreach is that its funding has historically been sporadic and unreliable. When budgets are cut, outreach is usually the first service dropped. Limited resources are then directed to clinical services. When funds are available, it is essential to use them efficiently and effectively. Often, broad public information campaigns do not reach the women who most need the services. There exists a lingering doubt in many people's minds as to whether the money spent for information campaigns accomplishes the goals intended. On the other hand, when outreach funds are targeted too specifically, a cost-effectiveness issue is raised. For example, funding outreach workers to find women in communities and bring them into care, while effective for a limited few, is very expensive. States question whether this is the best use of scarce funds.

Yet even when program funds are available for outreach, perhaps the monies should initially not be used for that purpose. NGA's report *Reaching Women in Need of Prenatal Care* and the Institute of Medicine's report *Prenatal Care: Reaching Women, Reaching Infants* both caution against funding outreach programs that attempt to recruit women into an unresponsive system of care. If a system is difficult to access and unsatisfying to use, outreach will not persuade women to enroll. Thus, the system itself must first be improved before efforts are made to reach out to pregnant women and recruit them into a program.

The Institute of Medicine's Report on Outreach

The Institute of Medicine's outreach study makes four major recommendations for improving the prenatal care system. The first is to remove financial barriers to care. The second is to make certain that the basic system capacity is adequate for all women. The third is to improve the policies and practices that shape prenatal care at the delivery site. And the fourth is to increase public information and education about prenatal care.

Nearly all states have begun to remove financial barriers to care through Medicaid expansions. Strategies to attract providers to serve these women – to ensure that the capacity of the system is adequate – are addressed in a later chapter. This chapter discusses strategies to improve the policies and practices at health care delivery sites and one state's public information and education campaign about prenatal care.

As a way of addressing policies and practices at the delivery site, the Institute of Medicine's committee on outreach further recommended that those responsible for providing prenatal services periodically review and revise office or clinic procedures to make certain that access is easy and prompt, bureaucratic requirements minimal, and the environment welcoming. Equally important, women should be encouraged at these sites to continue care. While public education campaigns are needed, they will be more effective if coupled with institutional reforms.

What are the specific problems with the provider facilities that need to be remedied? A few examples follow:

- Can the pregnant woman get through to the provider by phone, or are the phone lines always busy? A prenatal care committee in one city tried to call a clinic and the phone rang more than 100 times before anyone answered. This problem exists all over the country.
- How long does it take to obtain an initial appointment? In many areas women do not receive first trimester care, not because they do not seek it, but because they cannot get an appointment before three months pass.
- Is the first visit inviting, or is it focused on financial issues and thus discouraging? The first visit is an opportunity to tell a pregnant woman how important prenatal care is throughout pregnancy. That opportunity is often missed.
- How long does the pregnant woman have to wait on the day of her appointment? It is estimated that for every half hour a woman waits after the first half hour, she will miss a scheduled appointment in the future. Clinics or offices should explain the reason for a long wait.
- How difficult is it to get to the clinic? Transportation is a problem for most low-income women.
- Are child care services offered to mothers who must bring their children to the clinic? Many women miss prenatal appointments if no one is available to watch their children while they see a doctor.

- Can the client reach the provider by phone not only to make the initial appointment, but also to cancel an appointment? Has the pregnant woman been advised to discuss puzzling signs or symptoms with the physician or nurse-midwife? Can that provider be reached on the phone? Most clinics have multiple phone lines, but the same ones are used to make initial appointments and to report unusual pains or symptoms. Two separate phone lines are needed—one advertised as the number to call for an initial appointment or to change an appointment, and the other for patients to use in emergencies.
- Are there evening hours? Many women are not able to give up a day of work in order to receive prenatal care.
- Does the prenatal care provider refer women elsewhere for essential services? Pregnant women experience difficulty getting to one site for a smoking cessation program, a different site for WIC vouchers, and another location for clinical prenatal care. These services should be brought to the prenatal care clinic to ensure comprehensive care. Perhaps drug-abusing pregnant women serve as the best example a group in need of integrated services.

An example of a system that has instituted change is the network of health department clinics in Washington, D.C. Faced with one of the worst infant mortality rates in the country, the commissioner of health declared that no woman would have to wait more than two weeks for an appointment. He did this by reducing the number of appointments scheduled for low-risk women. He also instituted evening hours. He scheduled appointments so that clinics were not "cattle calls." Although many thought the women were not reliable and would not show up for their appointments, these changes have made a difference and women have kept their appointments. The commissioner also acquired a mobile van, the "Mom Van," and sent it out to pick up women who missed appointments. And finally, he went on television and told women in Washington that if they or their family earned less than $20,000, they were eligible for care. He didn't talk about Medicaid eligibility. He didn't talk about assets. He just said, "Come in. We'll provide the care."

Public Information Campaign in Utah

Utah has also instituted significant changes to improve delivery of prenatal care. Not only has the state addressed financial and eligibility barriers, but it also provides prenatal care coordination and expanded services for pregnant women, such as nutritional assessment and counseling, psychosocial assessment and counseling, and prenatal education. By the end of December 1987, the state had the capacity statewide, through health departments and other public providers, to provide a system for entrance into prenatal care as well as the delivery of care. With these systems in place, the state began a major media campaign in March 1988.

The "Baby Your Baby" campaign in Utah uses public service announcements, documentaries, and printed materials to advertise the importance of early and

continuous prenatal care. However, this media campaign is especially unique. Aspects of the campaign that make it so include:

- **Partnership.** The local television station, KUTV, an NBC affiliate, joined forces with the Department of Health, the local Blue Cross/Blue Shield, the local medical association, and the local March of Dimes. Usually those types of organizations – private, public, and nonprofit – do not have similar agendas. Regarding infant mortality, however, their agendas all meshed. Each organization has a voice in every decision that is made and in every action that is taken by the campaign. There is an executive committee with a representative from each organization that decides what is done, how it's done, when it's done, and what is said. Because it is a partnership, the campaign is a priority for each organization. All are equal partners.
- **Multi-Faceted.** The importance of prenatal care is communicated through multiple levels ranging from televised public service announcements to a toll-free hotline that women can call to speak directly with an expert. Additionally, the campaign includes documentaries, brochures, viewer guides, radio programs, radio public service announcements, seminars, and conferences. The reason behind this multi-faceted approach is that not everybody is receptive to the same type of communication. A multi-faceted approach accounts for individual differences in the way people receive and process information.
- **Long-Term.** Most media organizations like to do things quickly. In this case, however, each partner – including the TV station – has agreed to a two-year commitment, involving both money and resources. By going through at least two pregnancy cycles, they will be able to chart the changes in the state.
- **Uncontroversial.** Unlike many issues that are either controversial or unclear, encouraging pregnant women to get early, adequate, and repeated prenatal care, thereby leading to low infant mortality rates, is an issue that is straightforward and clear. It is an issue that is attractive to the media. Because of that linear aspect, it is an issue that can be addressed in a focused way.

One contributing factor to the successful reception of the campaign by KUTV was the way the health department approached the television station. The state did not ask: "What can you give to meet my needs? Can you give us air time? Will you run our PSA? Will you cover this issue on your news?" Instead, it considered the station's needs. They understood that the station needed imaging and definition in the community. All broadcasters want to establish a distinctive community identity. By marketing the project to KUTV exclusively, the state gave them the opportunity to be defined as the "Baby Your Baby" station.

The campaign has become a top priority to KUTV, resulting in prime time coverage. It gets exposure on every program produced by the station. To make a substantial impact, the state found it best to work with a strong station in an exclusive way.

The state also found that a television station needs editorial control. Because of licensing procedures with the Federal Communications Commission, stations are totally responsible for what they broadcast. If the media is approached as a partner, the message will get across in a way that has integrity and honesty. It is counter-productive to struggle with them for control of documentaries or their news series because the station has to protect itself.

Understanding that stations must cover their costs also has contributed to the positive relationship between the state and KUTV. The state approached the station by saying: "Let's form a partnership. And in this partnership, let's develop the resources necessary to develop all the components of this campaign in a way that has impact." In Utah that has meant a partnership of five organizations, each of which contributed both financial and in-kind resources. The cash contributions totaled just over $500,000. The in-kind contributions made this campaign worth more than $2.2 million.

Even at this initial stage, the state has begun to see some results. The number of applications for services in the "Baby Your Baby" program has nearly doubled in a year's time. In September 1988 the number of public service announcements rose to 200. During that same period, the number of hotline calls rose to almost 2,000 a month. Since there are 3,000 pregnancies a month in Utah, well over half of all pregnant women are calling. The phone company is keeping a computer record of every call, twenty-four hours a day, received by the hotline. In addition, KUTV is keeping a precise time log for every PSA played since the beginning of the campaign. Through these efforts, the state can show a direct relationship between TV promotion spots and calls to the hotline. It also hopes to show a correlation between PSAs, hotline calls, and applications to the prenatal clinics. And although it is too early to show outcomes, the state has found that the percentage of women who have entered prenatal care in the first trimester has been higher in the past few months of the campaign than it has ever been in Utah's history.

Conclusion

Realizing how important outreach to pregnant women can be to influencing birth outcomes, Medicaid has recently announced clarification on federal financial participation (FFP) for this activity. A February 10, 1989 statement reads: "FFP is available for state expenditures necessary for the proper administration of the state plan which is directly related to outreach activities."

Thus, federal funding is available to Utah (and other states) at a 50 percent administrative match for state expenditures devoted to outreach to persons potentially eligible for Medicaid.

State and federal agencies are becoming increasingly aware of the value of public education. It raises the awareness not only of the pregnant woman, but also of her family, who must support her in seeking that care. It also raises the awareness of the funders, providers, and policymakers. However, agencies have learned that it is unethical to urge women to come for prenatal care if there is no room in the program, if the services are inappropriate, or if the staff are hurried or rude. The first step in any outreach effort is helping providers to offer accessible, acceptable,

and appropriate services. Only after this has been accomplished can states begin public education campaigns to attract women into public prenatal care programs.

Panelists:

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3

Increasing Provider Participation

As thousands of newly-eligible pregnant women enroll into Medicaid, a severe obstetrical provider participation problem confronts the program. Obstetricians (OBs) and family practitioners are stopping obstetric practices at an increasingly rapid rate, due in large part to the rising cost of malpractice insurance. Those who do practice are increasingly reluctant to take care of high-risk women, causing direct problems for two public programs – Medicaid and Maternal and Child Health (MCH).

Over the winter of 1987-88, the National Governors' Association administered a survey to the Medicaid and MCH programs in all fifty states and the District of Columbia. The survey's purpose was to discover what was happening with provider participation in obstetrics for these public programs. Survey respondents identified three major reasons why they believed physicians are reluctant to participate in Medicaid or MCH:

- **Money.** In 1986, Medicaid paid an average of 44 percent of approximate community charges for total obstetrical care.
- **Management.** Bureaucratic hassles and billing procedures may require much of the time of the physician and/or the physician's administrative staff. In some instances these problems result in delays in payment and/or partial or no payment.
- **Malpractice.** Some physicians cannot afford to cover the costs resulting from the rising rates of malpractice premiums. Furthermore, a number of physicians are concerned that services to high-risk patients may expose them to increased risk of malpractice suits.

All three of these issues are probably equally important in analyzing why providers do not participate in public programs.

In addition to these predominant problems, other factors may add to the complexity of an already difficult problem. For example, there is a belief among the provider community that poor citizens sue more frequently than the general population. The American College of Obstetrics and Gynecologists (ACOG) reported in its study of the indigent that 40 percent of the obstetricians and gynecologists (OB-GYNs) believe that Medicaid patients are more likely to sue than non-Medicaid patients. While there is no conclusive evidence to prove this is true, this belief prevails. A look at the legal system makes one question the logic of this belief. The poor do not have much access to the legal system in general, so why would they have better access in an instance of a malpractice claim than in other situations?

Other intangible factors, while difficult to document, appear to affect some physicians' willingness to participate in public programs. Psychosocial problems that may affect pregnancy outcomes are often exhibited by low-income pregnant women. Some physicians may be reluctant to treat these women because their past training and experience has not equipped them to deal with their problems effectively. Other physicians may be concerned that provision of services to low-income women in their private offices will lead to negative reactions from their other (private-pay) patients and ultimately affect their entire practice. On the other hand, some low-income women may feel uncomfortable in physicians' private offices, particularly if they have other children whom they must bring to their prenatal care visits.

All of these factors contribute to the provider participation crisis in states' public programs. They have led to complex problems that require complex solutions. It is doubtful that just solving one of the problems will result in a significant increase in provider participation. As discussed below, the state of Massachusetts focused on improving fee levels, yet is still experiencing difficulty in making the system work.

Addressing the Money Issue in Massachusetts

As part of a major effort to address the issue of low provider participation, Massachusetts devised in 1986 a new and flexible system of global fees to reimburse obstetrical providers. Over the course of three years, the state doubled the rates for its standard global fee to $1,311. In addition, for providers who agree to provide enhanced psychosocial support services in tandem with routine care, the state offers an enhanced global fee at a rate of $1,653. That is the highest in the country and is well above the level of Massachusetts' Blue Cross/Blue Shield.

However, Massachusetts has been unable to determine from data analyses whether the raised fees have increased provider participation. Anecdotal information and cross-sectional surveys show that there are still problems with provider participation that have not been solved by the fee raises. But the kind of evaluation network and data system that is needed to track this on an ongoing basis is not in place between Public Health and Medicaid. Existing provider data files make it largely impossible to accurately identify the number of providers enrolled – a problem all states face. Physicians with provider numbers who see only one or two patients a year, group practices with one provider number, physicians with provider numbers who have retired or no longer see any Medicaid patients, and physicians with multiple provider numbers are some of the reasons why states are unable to track provider participation in their public programs.

In the mid-1970s, a study by Jack Hadley found that a 10 percent increase in Medicaid fees led to a 3 percent increase in participation. According to data from ACOG and data collected through the NGA survey, nineteen states raised their fees by more than 10 percent between 1986 and 1988. Some of these increases were 30 percent, 50 percent, or more for global obstetrics. Did those states experience an increase in participation of the magnitude that Hadley's data suggested they

should? Although nobody knows the answer to that question, it is doubtful they have.

One of the things Massachusetts did to try to gauge the impact of raising fees was to look at adequacy of care rates; that is, the rate at which women enter care early and the frequency with which they receive care. What was found was that increases in the global fee, over time, had very little impact on the adequacy of care rate. Once the global fee was split out, there were major problems getting high-risk women into care early and often. The adequacy of care rate decreased from about 78 percent in 1987 to less than 50 percent in one city with ongoing problems with provider participation in Medicaid.

Massachusetts has found that simply upping the fee is not enough to get a sufficient number of physicians to participate. The first step to improving provider participation may involve correcting a cumbersome claims system while tracking participation. Moreover, there are still many problems with administrative barriers – getting the payment to the physicians slowly or not at all. California, as the following discussion illustrates, has identified several strategies to address these administrative barriers.

Addressing the Management Issue in California

In California, four out of every ten claims for Medi-Cal (the state Medicaid program) are suspended – that is, they are held without payment until corrections are made. For physicians who do extensive obstetrics work, less than 10 percent of those suspended claims are ever paid in full. Participation in the program currently can cost physicians money.

To address this problem, the state has implemented a multi-faceted strategy. First, it established toll-free lines for physicians to discuss their obstetrical claims with Medi-Cal staff. It also has separate phone lines to confirm patient eligibility. Second, the state also sent representatives from the Medi-Cal fiscal agent into the field to physician offices with high error rates to train office personnel how to file claims correctly. Third, in an attempt to clear up some of the communication problems between fiscal agents and doctors (that result in tubal ligation claims being returned unpaid, for example) the state chapter of ACOG has designed a sterilization form for use by the physicians.

The state is exploring some other strategies as well. These initiatives include:

- **Tax Credit Bill.** Because so many physicians have said they would rather give free care than put up with all the bureaucratic hassles involved with Medicaid, the state has decided to give them that opportunity. A bill currently before the state legislature will allow tax credits on personal income for physicians providing free care.
- **Post Office Box for all OB Claims.** In the future, obstetrical claims will be sent to a separate address where staff will be trained to work just with those claims.
- **Changes in the Claims System.** Currently, if there is an error on one line of a claim, the claim gets kicked out of the system to be sent back to the

physician without identifying any other errors. The physician can correct the error and resubmit the bill. Under the present system, the computer scans the resubmitted bill and kicks it out again when it encounters the next error. This is called sequential editing. The state is developing a change in the system that makes it possible to identify all errors at once, before a claim is returned to a provider. This would avoid claims being sent back and forth repeatedly.

- **Reimbursement for New Technology**. New standards of practice (e.g., ultrasound) make it difficult for physicians to receive reimbursement. The state is trying to get these procedures added as standards of practice.
- **County Billing for Physicians**. In Mendocino County, the county has taken over the billing for physicians and pays them as though they are salaried. Through this, the state has identified numerous physicians in private practice who are willing to serve Medicaid patients if they do not have to deal with the other issues. The state is looking for ways to demonstrate this example to other regions as well.

Besides the bureaucratic issues that prevent providers from serving Medicaid patients, California and many other states are also trying to deal with the malpractice issue. In Missouri, an innovative approach was pursued.

Addressing the Malpractice Issue in Missouri

The state of Missouri has addressed the malpractice issue by a two pronged approach. In 1987 the Legal Expense Fund, a pre-existing self insurance fund provided by the state to cover liabilities incurred by its own employees, was amended to permit coverage of private physicians providing prenatal, delivery, or child care services under contract with a local health department. To be covered, these physicians could not receive more than minimal payment for their services. It was extremely new and controversial to provide coverage for professional liability to physicians who were not state employees. This, coupled with a new Medical Liability Reform Law passed in 1986, provided new, potentially powerful malpractice liability coverage to obstetrical care providers in Missouri.

Currently there are twenty-two private physicians participating in the program. These doctors are physicians who provide services such as prenatal care, child health examinations, and immunizations under contract with a local health department. At this time there have been no claims against the Legal Expense Fund from these physicians.

Given the extra protection allowed by the fund, many hoped that insurance carriers would reduce malpractice rates for doctors participating in the system. By March 1989, a decrease in physicians' private malpractice insurance rates had not occurred. Prior to amending the Legal Expense Fund law, the state did not obtain commitment from private insurance carriers to lower premium rates.

The Legal Expense Fund has been very helpful in encouraging physicians to provide services to local health departments, but has not been well accepted by OB/GYNs who provide delivery services. Hospitals that have self insurance

programs for staff physicians or residents, however, are becoming very interested in coming under this new protection.[4]

Conclusion

After twenty-five years, Medicaid programs still experience significant difficulties in assuring adequate levels of provider participation. In recent years, the traditional explanations of money and management have been exacerbated by the malpractice issue and other more elusive concerns. The problem is too complex to be completely resolved through traditional solutions such as increasing fees. Public administrators need to find out why doctors in their areas do not participate – and devise solutions to respond to those problems. In some cases, restructuring the public delivery system so that physicians are expected to provide medical services while case managers provide support to both patients and doctors may be the answer. In others, using certified nurse-midwives to provide some of the care may be the appropriate route. The important thing is, if these problems are not addressed, state agencies could spend millions of dollars on increasing fees, changing malpractice laws, and reprogramming computers without necessarily seeing an improvement in provider participation.

Panelists:

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II

ENHANCING THE DELIVERY OF CARE

"On the issue of infant mortality and extending coverage to more indigent pregnant women and children, we are the beneficiaries of an interesting 'twofer,' if you will. Seldom, in public policy, are we in a position to do the right thing both because it is correct from a human standpoint and because it is correct in an economic sense. It is extremely cost-effective to provide effective prenatal services to pregnant women and the appropriate follow-up services to infants, rather than to incur the astronomical costs of dealing with infants whose mothers have not received the proper kind of prenatal care. . . .

"The Health Care Financing Administration began, last year, a new Maternal and Infant Health Initiative to refocus our efforts and to set a new tone. We are now actively encouraging states to take full advantage of every option available to them in the Medicaid program to improve services to pregnant women and children. We want to reach out to state and local governments. . . to provide as much help as we can, working in concert with our colleagues in the Public Health Service, to try to improve the coordination and delivery of services to these populations. We have some fairly simple operational goals: first, to bring more eligible pregnant women into risk-appropriate health care management at an earlier stage; second, to bring more infants into health supervision; third, to improve the coordination of service delivery systems such as Medicaid, Maternal and Child Health, and WIC; and fourth, to begin to assess the effectiveness of these efforts to see if they have produced the desired results in terms of improved birth outcomes. . . . We want to make sure there's no question about the attitude, and the policy, and the approach of HCFA toward these issues."

Louis B. Hays, Acting Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
March 31, 1989

4

Coordinating Prenatal Care

One of the most common criticisms of the American health care system is that services are delivered through fragmented and disorganized systems of care, leading too often to a breakdown in continuity for consumers. Given the relative brevity of the span between conception and birth, the profound importance of the timing of prenatal care for fetal development, and the larger needs and risks faced by low-income pregnant women, it is difficult to think of a situation or a population that could benefit more by efforts to coordinate and improve continuity. Care coordination or case management is a system that addresses this need.

In recent years, no single concept has garnered more excitement or more confusion than case management. It has come to represent the ultimate panacea. On one hand, it improves quality by organizing and pulling together service delivery systems. On the other hand, it saves money because it improves efficiency and helps target scarce resources. For pregnant women, who often need broad and diverse types of services, case management systems enhance utilization and open doors to new services. (In an attempt to avoid semantical problems and distinguish this service from a gatekeeper model, the service will be referred to as care coordination rather than case management in the following discussion.)

In 1986 states were given a significant opportunity to rationalize perinatal service delivery systems under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Two provisions within COBRA made these opportunities possible. One offered state Medicaid programs the option to provide targeted case management as a service. The statute simply said that these systems could "help recipients gain access to needed medical, social, educational, and other services." States were given a great deal of latitude to define the service of case management.

A second provision within COBRA waived comparability rules to allow states to develop enriched prenatal benefit programs – that is, states could add new services for pregnant women without offering them to the rest of the Medicaid population. Within that enriched package of care, clearly, states had an opportunity to add a benefit such as care coordination. In addition, states have long had the option to pursue freedom of choice waivers as a means of controlling patient utilization and developing systems of coordination.

In 1988-89, the National Governors' Association conducted a survey of all fifty states and the District of Columbia to gain an overview of state efforts to coordinate perinatal care. Twenty-two states currently have in place care coordination for pregnant women as a specifically defined reimbursable service. Eighteen states have used the COBRA authority to provide the service, two states have freedom of

choice waivers, and two states have funded pilot care coordination programs with enhanced administrative funds. (See Figure 2.)

For a state deciding to adopt a care coordination program, a number of fundamental policy decisions need to be made: Which activities will be included within the definition of care coordination? Which provider groups are best equipped and most appropriate to deliver care coordination services? Given scarce resources, who should receive the care? Is the service to be a statewide benefit or should it be targeted to special populations? How and for what amount will care coordination services be reimbursed? Two states that have adopted care coordination programs and made these critical decisions are North Carolina and Maryland.

Care Coordination in Maryland and North Carolina

In North Carolina, Medicaid officials realized that in order to reduce infant mortality, they needed to do more than just provide prenatal care and improve Medicaid financing. Low-income pregnant women need assistance on a number of fronts to address their priority needs: transportation, adequate housing, school, employment, and basic resources such as food and nutrition. Officials felt strongly that pregnant women could benefit from the assistance of a professional support person and advocate. Such an advocate could help indigent women navigate a complex, fragmented health and social service delivery system. In the long run, such an advocate would be the catalyst for improving services by identifying issues that need to be addressed at the state and federal level.

The Baby Love Program was developed with a maternity care coordination component from this orientation. Baby Love also includes Medicaid expansions, outreach, and enhanced services. The legislation in North Carolina that authorized the care coordination service specified that Medicaid would cover only case management. The state Medicaid program had the money but limited service delivery experience. The state Maternal and Child Health program had the service delivery experience but no money. With only three months to operationalize the program, the two agencies realized that teamwork was not only desirable but necessary for achieving their objectives.

The two agencies began with formalized meetings and policymaking. Less formal coordination of effort was achieved through joint work committees. And finally, a very informal collaborative and co-administrative relationship was achieved. It was in this environment that the activities of the care coordination system were decided upon. (See pages 60-63 for a more detailed description of this collaborative effort.)

Maryland, on the other hand, developed its care coordination system much differently from the beginning. Unlike North Carolina, which offers maternity care coordination to all Medicaid eligible pregnant women, Maryland decided to target care coordination services to pregnant and parenting teenagers only. A history of high teen birthrates, along with the compelling desire to find better outcomes for adolescent parents and their children, led to the establishment of the Governor's Task Force on Teen Pregnancy in 1984.

One of the recommendations from this task force was that a council be formed to examine policy, called the Governor's Council on Adolescent Pregnancy. By looking at services and programs that already existed, the council became aware of the Single Parent Services Program housed in the Department of Human Resources. This program had been providing basic case management services for pregnant and parenting adolescents that were eighteen years of age or under since 1977. The council also found through data that the health care needs of adolescent mothers were not being adequately met.

The prenatal assistance program was funded in 1986 to provide maternity care for pregnant adolescents. This was a state-only program, providing prenatal care for teens (regardless of parents' incomes) who were below poverty level. Once OBRA-86 passed, however, the program was altered so the state could receive federal financial participation under Medicaid.

By using a different strategy, the council was able to get Medicaid to agree to the concept of care coordination. Instead of selling the idea to the Medicaid director, the council went to the Department of Budget and Fiscal Planning, which is responsible for reviewing the budgets of state agencies. The council proposed transferring $8 million of general fund money from the Department of Human Resources (the Single Parent Services Program) into the Department of Health and Mental Hygiene (which administers the Medicaid program) in order to draw down the 50 percent federal match dollars. The state was able to double the size of a state program without any new appropriations and began working toward bringing down the infant mortality rate.

Activities of the Care Coordinator. Maryland already had the activities in place that the care coordinators would perform. Through collaborative efforts, North Carolina officials decided upon those they saw as important to their program. Approaches to the definition of care coordination activities are fairly consistent in these two states and across most state programs, as evidenced by the NGA survey. These activities include:

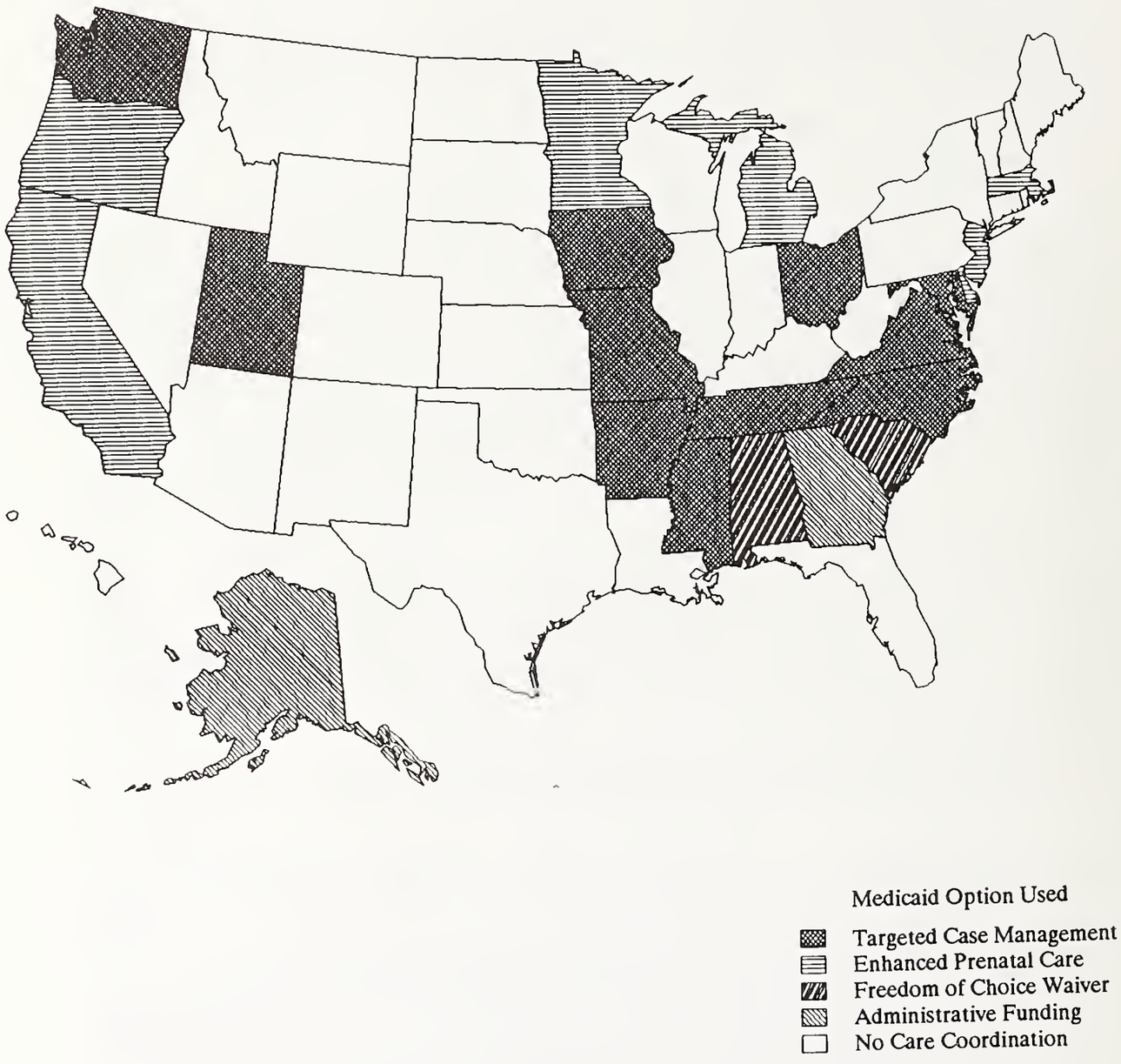
- Performance of a risk assessment to define the patient's needs;
- Development of a plan of care based on the outcome of the risk assessment;
- Coordination of the subsequent care and referral to address those needs identified in the plan of care; and
- Follow-up and monitoring to ensure delivery of those services.

Other activities identified by states as components of their care coordination service included assistance with eligibility (especially for those states that have adopted presumptive eligibility, including North Carolina and Maryland), assistance with transportation, and the use of team conferences. (See Table 2.)

Another important aspect of several states care coordination programs is advocacy. Given the fact that low-income, high-risk populations may be especially ill-equipped to understand what services they might need and/or have access to, many states have explicitly set out to create a category of providers who can serve as helpers. In Maryland, regulations require that the plan of care be developed

Figure 2

Medicaid Perinatal Care Coordination Programs
Use of COBRA Authority or Medicaid Waivers
July 1989



SOURCE: National Governors' Association, 1989.

Table 2
Activities of Care Coordinator

State	*Risk Assessment*	*Develop Care Plan*	*Coordination & Referral*	*Follow-up & Monitoring*	*Advocacy*	*Outreach/ Community Education*	*Assistance with Eligibility*	*Assistance with Transportation*	*Case Conference*	*Evaluation*
Alabama	■	■	■	■		■		■		■
Alaska	■	■	■	■	■	■		■	■	■
Arkansas	■	■	■	■			■	■		
California	■	■	■	■		■	■		■	■
Delaware	■	■	■	■		■		■	■	
Georgia	■	■	■	■	■	■	■	■		■
Iowa	■	■	■	■		■				
Maryland	■	■	■		■					
Massachusetts	■	■	■	■		■	■			
Michigan	■	■	■	■	■	■	■	■	■	
Minnesota	■	■	■	■	■					
Mississippi	■	■	■	■	■	■		■		
Missouri	■	■		■	■					
New Jersey	■	■	■	■			■		■	■
North Carolina	■	■	■	■	■	■	■	■		■
Ohio	■	■	■	■		■		■		
Oregon	■	■	■	■	■				■	
South Carolina	■	■	■	■	■			■		■
Tennessee	■	■	■	■	■		■	■		■
Utah	■	■	■	■	■		■		■	
Virginia	■	■	■	■	■	■		■		■
Washington	■	■	■					■		
Total	22	22	21	20	13	12	9	13	7	9

SOURCE: National Governors' Association Survey of Medicaid Perinatal Care Coordination Programs, 1989.

jointly by the care coordinator and the client, and that it be approved and signed by the client before it is put into effect. Emphasis is placed on "providing participants with information and direction that will enable them to successfully access and utilize health, social, educational, financial, housing, and other services identified in the plan of service." Care coordinators strive to empower the client and to assist her in understanding her needs and the actions she can take to address them.

Care coordinators in North Carolina also obtain signed letters of agreement with clients that outline the specific responsibilities of both the maternity care coordinator and the client. The maternity care coordinator agrees to help the client obtain medical benefits, prenatal care, WIC services, transportation, and information about other services available in the community. The client agrees to obtain prenatal care and WIC services, to keep appointments, to discuss family needs with the maternity care coordinator, and to follow the plan of care. In addition, maternity care coordinators evaluate the Medicaid eligibility status of clients. They refer the client to the local Department of Social Services or in-house for a presumptive eligibility determination, and follow-up with the Department of Social Services eligibility staff to monitor the certification process. Emphasis is placed on developing rapport with the client and a more personalized service approach.

Next, an assessment is completed and a service plan is developed. The assessment has been set up as a guideline and is subdivided into eighteen areas with suggested trigger questions to help maternity care coordinators collect the necessary information. The areas that are reviewed in the system include psychosocial, educational, nutritional, and medical needs. The questions range from feelings that the individual has about her pregnancy or her housing situation, to transportation issues and emergency assistance. As problems are noted or concerns identified, they are documented on the service form. Maternity care coordinators share the plan of care developed with the client, and both agree on the necessary intervention.

Following this, resources that the care coordinator can make available to the client are identified. A follow-up plan is established with the client. Periodic follow-up is conducted on a monthly basis or more often if dictated by the service plan or requested by the client. All missed appointments require an immediate contact by the maternity care coordinator. Both North Carolina and Maryland encourage care coordinators to make home visits to assess clients' situations more thoroughly. In fact, it is written in the Medicaid regulations in Maryland that at least one home visit occur.

Providers of Care Coordination. In North Carolina, local health departments were chosen to take the lead in establishing maternity care coordination statewide. Historically, they had been involved in these types of activities and there was a local health department in each of the 100 counties in the state. At the state level, the Maternal and Child Care section in the Division of Health Services was designated by Medicaid as the lead agency to establish a statewide care coordination system. In addition, other state agencies including rural health, social services, and mental health, were approached and invited to participate in the Baby Love program.

The state wanted to develop a process that would ensure that the care coordination service itself would not become fragmented with gaps in coverage or

overlapping functions and responsibilities between agencies eligible to provide care coordination services. The state wanted to avoid interprovider competition and client confusion over who their care coordinator would be. Yet, at the same time, it was aware that Medicaid could not implement a system in which clients did not have the freedom to select the provider of their choice. To meet the objective of implementing a statewide coordinated system to provide care coordination services and to ensure compliance with freedom of choice regulations in Medicaid, a three-step enrollment process was devised:

- **Enrollment of Local Health Departments.** Local health departments were asked to inform the state of their intent with regard to implementing care coordination services. They were also asked to identify and meet with other potential providers of care coordination services in their county and establish local written agreements for coordinating the care. These providers included rural health centers, Community Health Centers, Migrant Health Centers, Indian Health Centers, and private practitioners who had or could acquire the staff needed to perform this function.
- **Enrollment of the Other Providers.** Interested providers were encouraged to contact the local health departments and initiate agreements with them. Memorandums of understanding (MOUs) had to be established in counties where there were multiple providers of care coordination services. These MOUs had to specify which targeted population would be served by each provider; specify mechanisms for provider coordination of activities between the WIC program and other maternity-related services; indicate the qualifications of the maternity care coordination staff; and indicate that the provider offers prenatal care services to Medicaid-eligible clients.
- **Review and Approval of Provider Applications and Local MOUs.** Once the MOU is signed by the local health department and the community provider, copies of it along with provider applications are submitted to the state Maternal and Child Care section for review and approval by an interagency committee. This committee includes representatives from Medicaid, the state Office of Rural Health, the state MCH, the North Carolina Primary Health Care Association, and regional staff from Maternal and Child Health.

This system has worked well thus far. One benefit has been the development of more county-based coordinated systems between local health departments, Community and Migrant Health Centers, and Indian health services. As of March 1989, the state had enrolled eighty-three local health departments, six rural health centers, and one Indian Health Center. Although they are eligible, the state has found that private practitioners do not have the staff available to perform maternity care coordination. Instead, private practitioners prefer to refer clients to other local agencies for care coordination services.

In deciding what the qualifications of maternity care coordinators should be, the state considered various practitioners' level of community experience, ex-

perience working with pregnant women, as well as current health department staffing patterns. With this in mind, it was decided that care coordinators could be registered nurses with one year of experience in community health nursing and experience working with pregnant women, or social workers with a master's degree (MSW), or a bachelor's degree (BSW) and one year of experience in health and human services plus experience working with pregnant women.

In a very different model, care coordination services in Maryland are organized in and provided by the local Departments of Social Services (rather than health departments). Services are actually rendered by social workers that are trained at the master's or bachelor's level. The Departments of Social Services are the lead agencies for care coordination and work with all the local health departments.

The NGA survey found that, like North Carolina and Maryland, most states rely heavily on registered nurses and social workers to be care coordinators. However, a number of states also permit physicians, nutritionists, and other types of professionals to deliver care coordination.

Reimbursement. The survey also found that states use an array of approaches to reimburse care coordinators. Certain types of activities of care coordination lend themselves well to a capitation approach – paying a flat rate per month or per week. Other types of activities lend themselves logically to fee-for-service (for example, one fee for the performance of risk assessment). Some states reimburse at a higher rate for high-risk women. Others blend capitations with fee-for-service payments.

In North Carolina, officials wanted to ensure reimbursement at cost. To do this, they established a committee of local health directors and state staff to negotiate a fee. The committee recommended $100 for the first month of service and $20 per month thereafter. Medicaid's initial position was $25 per month for each client. The final policy established a rate of $50 for the first month of service and $25 per month thereafter, capping it at a total of $225. Although there was not enough time to do a study or separate research to evaluate an optimal caseload size for the maternity care coordinators, it was estimated that one full-time maternity care coordinator could handle 150 to 200 pregnant women per year, with 100 clients being served at any given time. The state estimated that average reimbursement would provide $200 per case and that, with the caseload size, this would provide $30,000 to $40,000 a year for a full-time position.

In Maryland, the reimbursement approach was a little different in that officials decided to front-load their payments. Under Medicaid reimbursement, the state pays $150 for initial case management services. Subsequently, the state pays $15 per month for ongoing care coordination services.

Unlike Maryland, whose program had been in place since 1977, North Carolina had to implement a totally new program on November 1, 1987. Preceding this date, a series of workshops were held across the state. Response was excellent. All 100 health departments and potentially eligible rural health centers were enthusiastic about proceeding with the development of the service. Local public health staff felt that they were already doing some of these activities, but not receiving reimbursement for them. Maternity care coordination allowed them to

return to "real public health" with emphasis on the community. They liked the manual (which had been developed jointly by Medicaid and MCH) because it was simple and allowed for flexibility. But most of all, they perceived the need for care coordination services and they agreed with the concept.

Experience thus far has been good. Some problems have been encountered, however, because of lack of start-up money. This has retarded full implementation. Some county administrators in North Carolina will not provide the funds to hire the staff and such monies are not yet available from the state. In some instances, the counties with the greatest need have the fewest resources. In terms of the care coordinator, this can result in burn out due to high caseloads and the inability to initiate services in some counties.

Successes in the maternity care coordination system in North Carolina include the following:

- It is operational in eighty-four counties.
- It has led to new and better relationships between the Department of Social Services and health care providers.
- It is generating sufficient revenues to support staffing and operations of the maternity care coordination systems.

In addition, some counties have used maternity care coordination to expand their local community efforts to initiate their own infant mortality reduction programs. Services such as special assistance for transportation have been put in place.

More important, care coordination is positively impacting clients. Beyond the obvious value of having additional staff to work with the families throughout the pregnancy, states have seen clients' relief when they realize there will be no large hospital bills to worry them. They are receiving services that promote better pregnancy outcomes. They are learning what those services are, where they are available, how to access them, and when to access them. They also have come to realize that they have a personal advocate who cares about their needs being met during the pregnancy and the first critical months of their infant's life.

In part due to the success Maryland has experienced with its care coordination program for pregnant and parenting teens, the state has recently embarked upon a broader, more comprehensive program of enhanced prenatal care services. On July 1, 1989, the state began offering care coordination to all pregnant Medicaid-eligible women, as well as basic health and nutritional education and home visiting. For clients exhibiting higher risks, the state now offers intensive psychosocial and nutritional counseling.

Conclusion

North Carolina and Maryland, as well as other states that have implemented care coordination systems for Medicaid-eligible pregnant women, are experiencing significant successes in helping women navigate the maze of public health and social service delivery systems. By opening the doors for these women to receive services,

better birth outcomes can be anticipated. The need for nonmedical support services that these women require can now be met through such a system.

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5

Enhancing Prenatal Care Benefits

Coupling expanded Medicaid eligibility with legislation authorizing expanded optional prenatal care services presents states with enormous new challenges and opportunities. The challenge is to ensure that prenatal care is provided to a greatly expanded client population. The opportunity is to extend a broad range of services addressing social and environmental risks in an attempt to reduce low birthweight and infant mortality. Financial access is not enough and care coordination cannot be effective without adequate services in place.

Two separate provisions in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) give states authority to enhance the content of their prenatal care benefit packages. One allows states to adopt enhanced prenatal care services for pregnant women without having to extend these services to the rest of the Medicaid population. The other allows states to adopt programs of targeted case management, in this context using the service to improve the continuity of care for the target population of pregnant women. States may also pursue waiver authority in order to develop special services and service delivery systems for pregnant women.

While states have been quick to expand eligibility for pregnant women and children, until very recently they have been much slower to enact service delivery enhancements. Although COBRA went into effect in April 1986, only five states had special prenatal care service programs in place a year and a half later. However, findings from an NGA survey of Medicaid Enhanced Prenatal Care Programs indicate that since November 1987, nineteen additional states have incorporated expanded prenatal services into their perinatal initiatives. There are indications that this trend of reforming the content of Medicaid-reimbursable prenatal benefits will continue. Such a progression in policy development reinforces the notion that eligibility expansions under OBRA-86 and OBRA-87 have served as a catalyst for overall system reform in state perinatal programs. (See Figure 3).

Many critical policy decisions face a state planning to revise and improve the prenatal care services it will provide through its Medicaid program. Consideration must be given to such questions as which services will be added, who will be certified to provide and bill for these services, how much these services will cost, and who will be eligible to receive them.

Because of the statutory language, states are given much latitude in selecting which services to include in their enriched packages of prenatal care. An ideal opportunity to assess the strengths and weaknesses of existing public service delivery systems is afforded to states during this decision phase, after which states

can creatively design benefits that may improve the system's capacity to serve the needs of low-income pregnant populations. (See Table 3.)

Once a decision has been made about which services will be offered, the state must then decide which types of providers are best suited to render, and thus permitted to bill for, the package of enhanced benefits. Options range from letting all Medicaid providers participate, to setting up rigorous certification processes that permit only some providers to participate. Yet another major policy question states must ask when adding enhanced benefits to their Medicaid program is: Who will be eligible to receive the extra services? Essentially, states may decide that all pregnant clients in the state should be extended the enhanced benefits or, conversely, they may opt to target benefits to specific sub-groups of pregnant women. Depending on the individual service or package of services added and the statutory authority pursued, states have a wide degree of flexibility to tailor their programs as they wish.

Determining how and how much to pay providers of enhanced prenatal services represents yet another difficult and complex task for state policymakers. Arriving at a schedule of fees that is equitable to the provider community and that meets state budgetary constraints can be nearly impossible. Levels of reimbursement must be adequate to ensure provider participation, yet also must be in a range that does not exceed budget allocations based on utilization estimates.

California, Michigan, and Minnesota have developed three very different models for enriching prenatal care benefits programs. In one, the overriding priority was to enhance comprehensiveness of care using multidisciplinary teams to provide a package of medical services and social support. This is, for most states, a familiar public health model long used in local health departments and Community Health Centers. In another the effort was focused on enhancing the scope of services in a manner that could best utilize the private physician-dominated system in the state. For the third, a multidisciplinary model was preferred, but concrete links were developed in an attempt to merge sometimes distant public and private health care delivery systems.

The Comprehensive Perinatal Services Program in California

In California, the Comprehensive Perinatal Services Program (CPSP) was built upon a model created under OB-ACCESS, a three-year pilot project conducted between 1979 and 1982. An evaluation of that project found a one-third reduction in low-birthweight infants. The CPSP, which was implemented in 1987, represents a joint effort between Medi-Cal and the MCH program, both located within the Department of Health Services. Services covered under the program include care coordination, nutritional services, health education, and psychosocial services in addition to traditional medical obstetrical care.

In designing the program, California placed major emphasis on improving the quality and content of prenatal services. MCH officials' priorities, which emphasized the use of multidisciplinary, clinic-model providers, drove the initial program design. Stringent application requirements are included in a two-step review process. CPSP county coordinators initially examine provider applications and recommend approval or denial. Applications are then forwarded to the state

health department, which administers both Medi-Cal and MCH. The certification of CPSP providers is completed by the Family Health Division of the state Public Health Department.

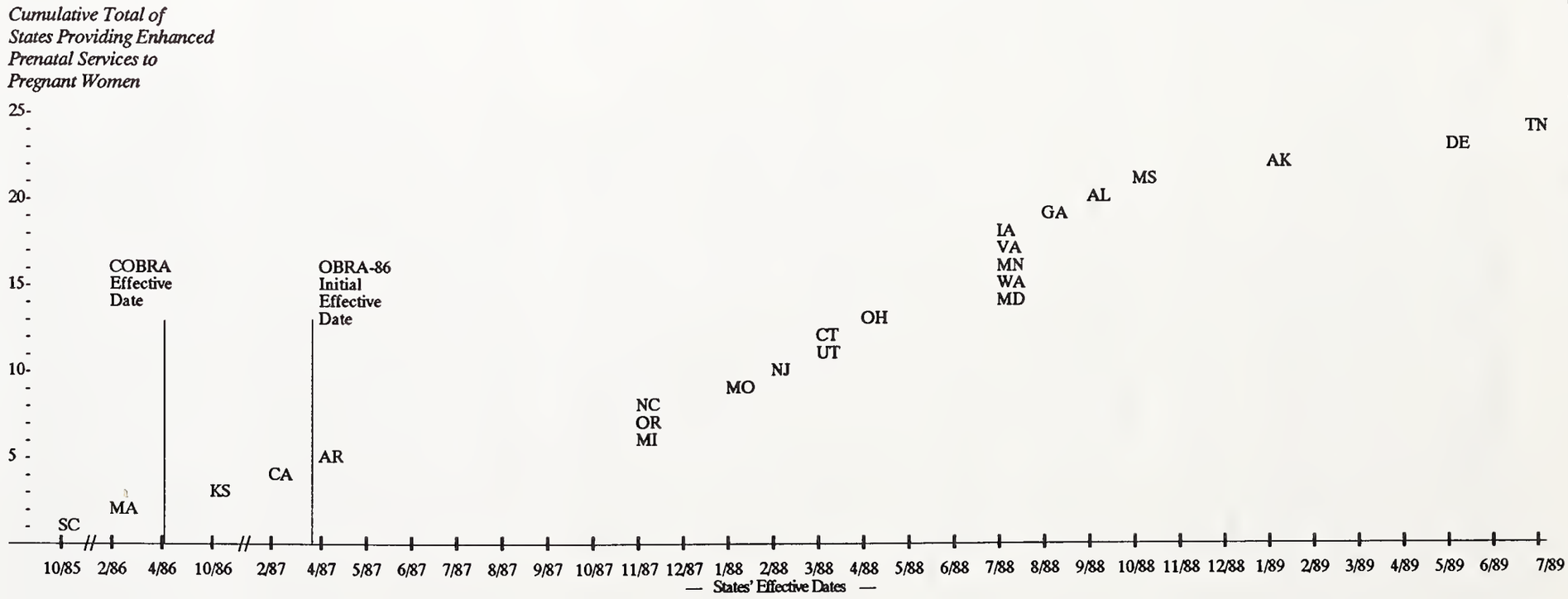
Although stringent application and review requirements are still necessary to become a CPSP provider, maximum flexibility is allowed in the models that are used by the provider. The state tries to work with the individual applicants and the resources they have available in their particular community to develop a model that works for the community and meets the regulation requirements. In addition, the state has no restrictions as to where the services must be provided. Supplemental services may be rendered in an office setting, a classroom setting, the client's home, or even in the hospital.

In order to become certified, the CPSP provider must be a physician, a certified nurse-midwife, or a group practice possessing one of these disciplines. Each provider is required to establish protocols for nutrition, health education, and psychosocial services. The protocols must also be approved by a dietician, social worker, or health educator in their respective area of expertise. Services that are not rendered directly by the CPSP provider must be under the supervision of a physician. In other words, the physician must evaluate the services through direct communication, either in person or through electronic means. The staff of the CPSP provider, which can include registered nurses, nurse practitioners, physician assistants, social workers, childbirth educators, or dieticians, may render the actual services. In addition, the health education can be delivered by comprehensive perinatal health workers with the following qualifications: at least eighteen years of age, a high school graduate or equivalent, and at least one year of full-time paid practical experience in providing perinatal care; or a licensed vocational nurse with one year of experience in the field of maternal and child care.

Initially, the emphasis on quality created an access dilemma for the state. The original project required primary providers to employ a multidisciplinary team in order to become qualified CPSP providers (i.e., all CPSP practitioners would need to practice under one roof). During the regulatory process, testimony indicated that this requirement could, in fact, present a barrier to access. Simply stated, private practice physicians could not realistically be expected to hire the necessary staff and obtain the necessary space to deliver CPSP services. Physicians in rural areas, especially, could not gather all those resources. Because a large proportion of indigent women in California seek care from private providers, the original CPSP model, which was initially designed to improve the quality of care, might be largely inaccessible to many women. Consequently, the requirement was modified so that the physician may contract with practitioners to provide the interdisciplinary services.

To facilitate the implementation process, the state, jointly with Medi-Cal and Maternal and Child Health, conducts training for potential providers, often using existing providers to serve as delivery models. The state is available to assist providers in developing acceptable protocol and with billing procedures. The county health departments play a major role in administering the program at the local level. The local agencies inform the potential providers about the program, distribute applications, try to recruit providers into the program, assist them with

Figure 3
Implementation Dates of Enhanced Prenatal Care Programs



SOURCE: National Governors' Association Survey of Medicaid Enhanced Prenatal Care Programs, 1989.

Table 3
Medicaid Enhanced Prenatal Care Services

State	Care Coordination/Case Management	Risk Assessment	Nutritional Counseling	Health Education	Psychosocial Counseling	Home Visiting	Transportation	Original Effective Date*
Alabama	■	■				■		9/88
Alaska	■	■				■		1/89
Arkansas	■	■	■	■	■	■		4/87
California	■	■	■	■	■			2/87
Connecticut		■		■		■		3/88
Delaware	■	■	■	■	■	■		5/89
Georgia	■	■						8/88
Iowa	■	■	■	■	■			7/88
Kansas		■	■	■		■		10/86
Maryland	■	■	■	■	■	■		7/88
Massachusetts	■	■	■	■	■			2/86
Michigan	■	■	■	■	■	■	■	11/87
Minnesota	■	■	■	■	■	■		7/88
Mississippi	■	■	■	■	■	■		10/88
Missouri	■	■						1/88
New Jersey	■	■	■	■	■	■		2/88
North Carolina	■	■		■		■		11/87
Ohio	■	■	■	■	■	■		4/88
Oregon	■	■	■					11/87
South Carolina	■	■	■		■			10/85
Tennessee	■	■				■		7/89
Utah	■	■	■	■	■	■		3/88
Virginia	■	■	■	■		■		7/88
Washington	■	■	■	■	■	■	■	7/88
Total	22	24	17	17	14	17	2	

NOTE: *Original effective date reflects states' initial implementation of enhanced prenatal services.

SOURCE: National Governors' Association Survey of Medicaid Enhanced Prenatal Care Programs, 1989.

completion of the forms, and then, as mentioned above, make a recommendation to the headquarters of the MCH branch on the certification of those providers.

California, through compromise and collaboration, has reached a balance between quality assurance and access. The state has approved 175 CPSP providers, utilizing the services of more than 800 physicians and 120 certified nurse-midwives. Although it is still too early to realize results, the state is confident that CPSP will have successes similar to OB-ACCESS.

The Enriched Prenatal Care Benefits Program in Minnesota

Minnesota, like California, wanted to add prenatal services that would enhance comprehensiveness of care for high-risk, low-income pregnant women. Yet since the majority of care provided to medical assistance clients in Minnesota is delivered through private providers, the state placed high priority on creating a system that would not jeopardize access or alienate current providers. In establishing a program that could be adapted and utilized by all private providers but that also offered more comprehensive care, the state decided to include in the package of services high-risk antepartum management, care coordination, health education, nutritional education, and a follow-up home visit.

Although these services are similar to those included in many states' enriched benefits programs, the Minnesota program does have some unique aspects. For example, health education is divided into two parts – one more intensive than the other. The initial curriculum includes childbirth preparation and specific information about pre-term labor, especially how to recognize its signs. Health Education II is the component that allows the providers to focus on the specific client's identified risk. It can be smoking cessation, coping skills, or preparation for parenting, for example. The high-risk follow-up home visit is also a service not found in all states' perinatal initiatives. The purpose of the home visit is to determine if there is a need for continuing involvement with the client. The visit must be completed within two weeks of the woman's discharge from the hospital after delivery.

Minnesota, unlike California, has not instituted a special certification process in order to select participating providers. All Medicaid providers can bill for these new services. Although the package of services was selected with the private provider in mind, the state recognized that there may be other providers more appropriate to deliver some of the services. Thus, as in the California program, the certified nurse-midwife and physician are recognized as the primary medical care providers. Only these disciplines can do the risk assessment and bill for the high-risk antepartum management. Other providers can deliver care coordination, health education, nutritional education, and home visits. No other provider, though, can bill for these services without a physician or certified nurse-midwife referral.

The Minnesota program is targeted to low-income women at risk for low birthweight and pre-term labor and delivery. A comprehensive risk assessment, defining the enhanced services to be provided, and to whom, is the key to the program. If a woman scores ten points or more on the risk assessment, the system allows for her to receive the expanded services. The primary provider uses this tool to plan services and initiate referrals.

Minnesota, like California, has found it necessary to become involved in helping providers set up the new system. The state initially sent letters to every provider and provider organization that could possibly participate in the new program. Initially, it received great support and interest from public health nurses, community clinics, and WIC, but little response from private physicians. What was soon discovered was that the private providers wanted more direction and innovative ideas on how to translate the program to actual service delivery. To address this, the Department of Human Services (which contains Medicaid), in cooperation with the state health department, applied for and received a Special Project of Regional and National Significance (SPRANS) grant from the federal Office of Maternal and Child Health.

The SPRANS grant allows Minnesota to hire three perinatal nurse educators to help implement the new program. The professionals will meet with OB providers participating in Medicaid and support other efforts to build strong relationships between public health nurses and private physicians. Perinatal specialists will work with the state medical association to bring together physicians and public health nurses. The state feels that strong relationships between these two groups will go a long way toward building a more solid base for the enhanced prenatal benefits program. Another important component of the program, made possible by the SPRANS grant, is evaluation. The grant allows Medicaid to contract with the University of Minnesota and MCH specialists to conduct actual record reviews. Evaluation of the quality of the education of the physician and public health nurse and evaluation of the quality of the services that are being provided under this enhanced package will be performed. This will make it possible to make future changes in the program based on actual and real information.

In addition to these efforts, one person employed by Minnesota Medicaid devotes her full time to the implementation of this prenatal care initiative. She is available to work with advocacy organizations, to promote outreach, and to work on community relations. She also visits specific provider offices and other provider groups involved in the program to assist them with billing and any problems they encounter. This is extremely helpful because it gives providers a contact person to call in Medicaid.

Minnesota found that a significant effort is required to establish a program that can be adapted by private physicians. The most critical goal of the initiative, as well as its greatest challenge, was to encourage physicians to alter their practice and render social support as well as medical services, or to recognize more appropriate providers for these services and initiate referrals to them. Trying to accomplish both these objectives is a significant challenge, one that Medicaid and MCH officials, working collaboratively, believe they have begun to meet successfully. An indication that the new program is gaining acceptance among the provider community is a recent change in Blue Cross/Blue Shield. The managed care option plan of this health insurance company has begun requiring services similar to those included in the state's prenatal care program. Blue Cross/Blue Shield has agreed to accept the state's risk assessment tool. This not only helps give the state program integrity, but also shows recognition – a significant accomplishment of which the state can be proud.

The Maternal Support Services Program in Michigan

As was the case in California, Medicaid and Public Health officials in Michigan wanted to design a program that ensured comprehensive care and utilized a multidisciplinary team. As in Minnesota, however, these officials did not want to jeopardize access by alienating private physicians. The Maternal Support Services Program (MSSP) was established to meet this goal. The program provides preventive health services to pregnant and postpartum women. Services are delivered by a specially certified agency that is staffed with a multidisciplinary team. Services provided in the benefit include psychosocial and nutritional assessment, nutritional counseling, social casework, public health nursing intervention, childbirth education, transportation for medical and related appointments, and assistance with obtaining child care that is necessary to keep medical and related appointments. Care coordination is not stated as a separate service within this package, although it is implied.

Rather than attempting to change the practice patterns of private physicians, per se, Michigan hoped to create strong referral networks between private and public providers. Under MSSP, enhanced services are available only to pregnant and postpartum women viewed by their primary care provider to be at high risk of a poor birth outcome. State officials developed and circulated to all obstetrical providers a broad screening tool. These caregivers were asked to evaluate the risk status of all pregnant women based on categories such as support systems, parenting experience, feelings and attitudes toward the pregnancy, emotional status or ability to cope, educational and developmental health status, nutrition, and substance abuse. Like the Minnesota program, this risk assessment is the trigger that enables women to receive maternal support services. If a woman is believed to be at high risk, physicians are asked to refer her to an MSSP agency, where her needs are more fully assessed. After that assessment, it is decided which of the enhanced services will be provided. The assessment must be conducted by at least one of the three disciplines allowed to provide these new services – registered nurses, social workers, and nutritionists. All three disciplines must participate in the development of a plan of care, even if they do not actually participate in the assessment. In addition, the state asks that the assessment be completed during a home visit if at all possible. It is felt that seeing the woman in the home environment gives the most insight into her particular situation.

One of the main philosophies in this program was that support services should be coordinated with the primary medical provider. The MSSP agency is required to communicate with the medical provider regarding what is found through the assessment. In addition, the agency informs the doctor what intervention will take place and the results of the intervention on an ongoing basis. The doctor can also use these opportunities to share information about the client with the agency. In this way the client is assured of receiving comprehensive care. This also establishes a concrete link between public and private providers – one that has often been lacking in the past.

In an attempt to assure that high-quality support services are rendered, Michigan, like California, requires certification of their support service providers.

In developing the program, the state health department originally wanted to limit the pool of MSSP providers to the existing network of local health departments. Medicaid, however, was much more interested in opening it up to multiple qualified providers. They reached a compromise in which the health department was able to set educational and experience requirements for each member of the multidisciplinary team that each agency is required to employ.

Michigan actively solicited applications from all possible provider groups to deliver the new benefits in an attempt to facilitate implementation and assure access. Medical providers were contacted; ACOG and state medical society conferences were attended; and home health agencies, local health departments, hospitals, health maintenance organizations, Community Health Centers, and other agencies were informed about the new services. The state was also involved in writing articles for association letters informing providers about how to apply. It was a very open process.

The state health department has the responsibility to carry out the certification process of the provider agency. Agencies are required to have one of the three disciplines (nurse, social worker, and dietician) as full-time staff; the others can be contracted out. The agency must have the capacity to make both clinic and home visits. In addition, they are required to provide all the services available under the program. A written application, which is reviewed by the state health department, must be submitted first. During the review, a determination is made of whether more information is needed or whether it can be approved as is. If approval upon paper review is made, then it is submitted to the Medicaid agency which issues an interim approval for the agency to begin providing service. Based on this interim approval, that agency can bill Medicaid for services provided. Once the agency has been providing services for at least one month, the health department conducts a site visit to complete the certification process. The results of that visit can be full certification, which is good for a two-year period, or a probationary certification, which means that there are some problems in the agency. The problems are cited to the agency and the health department works to help correct them. The health department then returns six months later to see if the problems have been resolved and if full certification can be given.

In Michigan, as opposed to Minnesota, a large number of low-income women receive prenatal care through clinics. Thus, coordination of services is less of a problem. These women are automatically referred to the multidisciplinary team, located in the same clinic. This year, however, the state has experienced an increase in physician referrals. Medicaid can be credited for this increase. The agency clarified its high-risk reimbursement policy for the medical prenatal care package to indicate that it included psychosocial and nutritional risks. But to claim the high-risk package (and receive the larger fee), a referral of that patient to an MSSP provider must be made. With this new financial incentive, not surprisingly, private physicians have begun to refer their clients to MSSP more frequently than was done in the past.

Currently, the state has eighty-four agencies that are certified to provide the new services. Forty-five of these agencies are local health departments. However, a significant number of hospitals, home health agencies, and other agencies (e.g.,

HMOs, Migrant Health Centers, Community Health Centers, and community service agencies) are certified as well. State officials are quite pleased with both the number and distribution of MSSP providers and believe that women residing in every part of the state can access the benefits.

Conclusion

Although it is too early to see measurable results from any of the new enhanced prenatal care benefit programs, most states feel that these programs are helping meet the needs of low-income pregnant women. Medicaid agencies across the country have begun to realize that it is extremely difficult to separate work, home, family, nutrition, and environment from the health manifestation associated with maternity care. Through collaborative efforts with their Maternal and Child Health agencies, programs are being set up to meet the nonmedical needs of the pregnant population.

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Integrating Local-Level Service Delivery Systems

As state policies to expand Medicaid eligibility and covered services continue to be developed and implemented, state officials must turn their attention toward the community to see how all these policies and programs are translated. Do these programs successfully serve the people to whom they are targeted? Integrating local-level service delivery systems is crucial if states are to impact health status and birth outcomes. While encouraging progress has been made between state Medicaid and Maternal and Child Health agencies to collaborate on programs, carrying these efforts to local agencies presents another challenge. Communicating policies and programs to local-level agencies in a clear and understandable form can be difficult. However, smooth implementation depends on open lines of communication not only between state and local officials, but also between the multitude of providers rendering care at the local level. Players that must coordinate with the state as well as among themselves include local health departments, rural health centers, Community and Migrant Health Centers, Indian Health Centers, and private physicians and certified nurse-midwives. These providers are trying to deliver care to low-income pregnant women while facing numerous challenges. Especially relevant is an increased demand for prenatal services confronted by these local-level service delivery systems.

A major reason for this increasing demand is the dwindling supply of private providers willing to render obstetrical care to poor populations. The malpractice crisis has contributed to conditions such as large areas where no obstetrical care can be obtained. Such problems are especially acute in rural areas. Another reason for the increasing demand for prenatal services is the continued expansion of services to these special groups. For example, Medicaid expansions are opening the doors for many pregnant women to obtain prenatal care.

This demand for prenatal services is creating several challenges that must be faced by local level service delivery systems, including:

- **Fragmented systems of care within the public health care sector.** In many areas of the country, little opportunity exists to link systems into a model that will allow an entire public health care system to benefit from the economies of scale and the allocation of resources.
- **Issues of malpractice and liability.** These issues have affected not only the number of providers available, but also the number of procedures necessary to monitor patients. Ultimately, this generates significant increases in costs and outcomes (e.g., high Caesarean rates).

- **The significant change in how to do business**. In many areas of the country, local officials philosophically disagree with the public sector system charging fees. This can create problems especially for localities that do not have the experience to recover funds now available through Medicaid. Further, revenues gathered by public health providers do not always remain in the possession of these providers. For example, in San Antonio, city ordinances require money brought in through health departments to be channeled back into the city general fund. Each year, local health officials must argue for increased budget allocations. Thus, it is difficult to allocate monies for prenatal services when they are taken out of the health departments.

Several strategies have been identified by local delivery systems to address these challenges. These strategies include:

- Increasing the use of nurse practitioners and nurse-midwives in the public health care system. Communities must be able to support these professionals as they maintain their certification, their credentialing, and opportunities for continuing education.
- Ensuring that fees generated within a health department are kept there rather than put into a general fund for the community.
- Expanding the utilization of local practitioners on a contractual basis. Private practitioners trying to get established in a practice can represent a valuable resource to the community.
- Bringing physicians and other providers under the city or state umbrella liability coverage. By doing this, states can help ensure that communities have an adequate number of obstetrical providers.
- Improving coordination among all of the different local providers within the public sector, including hospitals, Community Health Centers, local health departments, and private practitioners. This coordination should be extended to the state level as well.

This last strategy is probably the one states are most often and most aggressively trying to implement.

Issues Confronting Community and Migrant Health Centers

Virginia, working to improve relationships between local health departments and Community and Migrant Health Centers, established the state Primary Care Association. The state realized early on that the role of these centers was not widely known. Thus, the first step in coordinating local-level providers was to inform state MCH and Medicaid agencies about these providers.

Across the country, Community and Migrant Health Centers provide a large portion of primary care to indigent people. All Community and Migrant Health Centers have to provide care to Medicaid recipients. Funded by the Bureau of Health Care Delivery and Assistance, there are more than 500 Community and

Migrant Health Centers across the country that serve more than 5 million residents. The program is based on three missions:

- Community and Migrant Health Centers are not-for-profit, community-controlled corporations. They have boards of directors and are located in medically underserved areas.
- Community and Migrant Health Centers create systems of care, accessible to all, regardless of the patient's ability to pay. Sliding fee schedules are used.
- Community and Migrant Health Centers are more than just doctors' offices. Multidisciplinary providers are concerned with prevention as well as treatment. They are involved with the community and with patients.

In most states, primary care associations have been established to create an organizational environment for cooperation between Community and Migrant Health Centers and state and local public health programs. The associations have identified three principles that are essential in building successful relationships:

- Local cooperation has to be supported at the state level. Virginia found it to be most effective when the local staff agree on what has to be done and then take it to the state level.
- Both parties must agree that there is never enough money to meet the needs of poor people. Ensuring that both organizations are aware of the futility of squabbling over who is going to provide services to poor people is essential to building a cooperative relationship.
- There is a basic lack of information on services, goals, and regulations between local Community Health Centers and local health departments. This affects provision of Medicaid certification and services to perinatal Medicaid users. The only way to resolve this lack of understanding is to promote opportunities for interaction, communication, and explanations.

To facilitate cooperation between the Community and/or Migrant Health Centers and the local health departments, Virginia has supported service integration projects. The state has directed monies to areas of the state for local health departments and Community/Migrant Health Centers to plan and implement projects together. These projects have involved public health nurses from health departments working with Community Health Center doctors, for instance, to put new or expanded services together. The state has also worked very hard to make sure any new Community Health Centers are developed in coordination with local health departments; that boards of directors of new centers include local health department staff; and that the health department data is shared as part of the needs assessment for the centers. Health departments are asked to use the new centers on a contract basis for services once they are operational and centers are encouraged to become "contract physicians" at local health department clinical sites.

In working together, the two organizations have come to realize that they have similar goals and similar mandates of services to offer. The semantical language

barrier is probably the biggest obstacle in working together, especially with Medicaid eligibility. However, through commitment and persistence the state has been successful in coordinating and improving access to prenatal care for low-income women.

The Role of the State Medicaid Program in Facilitating Local-Level Implementation

Washington, through the state Medicaid and MCH agencies, has also been active in trying to integrate all local service delivery systems in order to meet the increasing demand for maternity care. The Alternative Delivery System Project is a component of the First Steps program, the comprehensive plan for improving maternity care access in the state. The project prioritizes counties that are facing severe access problems. Working with these communities, the project's goal is to develop delivery systems that integrate all local services, using all available resources to meet the needs of the women in the community. As part of the project, representatives from Medicaid and Parent Child Health Services (the state's MCH program) go out together as part of a consultative team to the counties.

A primary problem that state officials had to resolve, initially, related to state organizational structures. Although the players involved are all under one umbrella agency, the Department of Social Health Services, they still have to work through separate hierarchies to accomplish their goals. This often creates problems. Yet, as in Virginia, state staff have come to realize that they must be able to work together at the state level before they can facilitate cooperation at the local and county level.

The state decided that in order to address access problems, attention had to be specifically focused at the community level. The community had to solve its own maternity care access problems for the solutions to be effective. The following outlines the process that the Alternative Delivery System Project uses to facilitate cooperation:

- All the actors involved in maternity care in the community are brought together. Private doctors and representatives from the local health departments, Community Health Centers, and Migrant Health Centers are included.
- At the initial meeting information is shared by the state about the problem in a particular county. Statistics such as birth outcomes, percentage of Medicaid births, minority births, and teen births are shared with the local providers to prove that a problem exists.
- Current program activities of the state are described. This informs the providers that the state office is aware that they are having problems; that the state office is aware of the extent of those problems; and that something is being done to address those problems.
- The local providers are given the opportunity to talk to state staff about their problems. The state has found that locals have built up a lot of resentment toward Medicaid because of billing and reimbursement issues. Project staff have found that while this can be unpleasant, it is

important to get these complaints out of the way in order to move forward on solutions.

- The state staff makes sure that the community representatives acknowledge that a problem exists.
- The state staff initiates discussion about who owns the problem. The community has to accept ownership of the problem in order to resolve it.

Once the community acknowledges that it has a problem, solutions can be discussed. The state helps ensure that all agree to work together on the problem. They make sure that all in the room realize they have a stake in solving the problem. In going out to the counties, the teams have found that every county has a different set of relationships. The team may not always be aware of the history behind many of the relationships. Thus, getting communities to start looking at solving this problem as a collaborative effort may be difficult at first.

The state is currently working with seventeen of the states' thirty-nine counties to develop an alternative delivery system. Six of the counties have submitted proposals; four have been approved. In working with these counties, the state has identified factors that enable a county to be successful in working together to integrate resources:

- **Time and readiness are key to success.** The state is realizing that counties must be given as much time as they need to work through their problems. Trying to push a county for solutions when the multiple providers have a history of not working well together is not productive.
- **Hospitals are important.** In the beginning, state officials thought they had to work only with the prenatal care providers. They have found, however, that hospitals must be involved because in many areas, the hospitals are covering the malpractice insurance for doctors who work in prenatal clinics. Hospitals can persuade doctors who have privileges at the hospital to participate.
- **The Medical Society is a key element.** Private physicians must buy into any system for it to be successful. By working with local medical societies the state can ensure that local physicians are involved.

One factor of the system that has been a surprise to the state is that in many instances what happens in a county can hinge on a personality. To address this, "problem people" are identified early so that they can be worked with individually. Three examples of county initiatives are described below.

One county's proposal involves a collaborative effort of a private physician practice, a farm workers clinic, an Indian health clinic, and the local health department. The proposal, which the state is reviewing and approving, establishes a system in which the local welfare office agrees to expedite eligibility, including making home visits, if necessary, to ensure that a woman is made eligible. The community has agreed to refer all women to the health department, which can then refer them to other alternatives for care. The health department is taking the responsibility for ensuring that women do get into a system of care once the referral is made. They

will help women make an appropriate choice of care. The health department also will provide support services – case management and assistance – in getting through the eligibility process.

Grant County in Washington is another area of the state where the Alternative Delivery System has been active. In this county, the problem has centered around the appropriate role of the Migrant Health Center. For various reasons, an unreasonable 64 percent of the Medicaid deliveries are done in the Migrant Health Center. Two family practitioners in this center are each delivering ten to twelve infants a month. This is in addition to all the family practice care for which they are responsible. Fifty percent of the pregnant women are going outside of the county to receive care, causing problems in surrounding counties as well. Although Migrant Health Centers have always been able to receive revenue from Medicaid, this center like others around the country, has not historically taken advantage of this resource. To address this problem the state is working with the Migrant Health Center to aggressively bill Medicaid.

Grace Harbor County in Washington, on the other hand, has relied on the traditional physician OB care delivery with very little involvement by the health department or Community Health Center. Ninety-two percent of the Medicaid deliveries are performed by one OB practice with three physicians. In addition, patients from other counties come to Grace Harbor to receive care. Exacerbating the problem, a hospital credentialing committee makes it extremely difficult to obtain delivery privileges at the hospital. The physicians firmly believe that the standard of care will be compromised if other providers are allowed to deliver. Consequently, the physicians will not consider integrating resources in order to improve access for low-income pregnant women. To address this problem, the state is trying to get ACOG and the Medical Society to intercede to persuade these doctors to be more flexible so access can be improved.

Washington has learned that the most important aspect of the Alternative Delivery System Project is flexibility. In one area of the state a local health department may be the leader in providing maternity care to low-income residents; in another it may be private physicians; and yet in another the Community and Migrant Health Centers may be most active as the three preceding examples demonstrate. Keeping this flexibility in mind when working with local-level delivery systems is key to the state's success.

Conclusion

Virginia and Washington have had varying degrees of success in working to improve coordination of the delivery system at the local level. Providers in the community face many challenges to ensuring that all women in need of services receive care. State staff through their own improved relationships can work together to ensure that this coordination translates down to the local level. Only after these systems are integrated can low-income pregnant women be cared for through an effort that takes advantage of all available resources.

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Evaluating Program Impact

Now that states have expanded Medicaid eligibility and are covering new enhanced services for pregnant women, there is an increasing need to determine whether any of these interventions have made a difference in health status and birth outcomes. It is a harsh reality that funding for most federal and state initiatives was obtained as a result of persuasive arguments that an investment in prevention can improve health status and save money. Now, state and federal legislatures are beginning to ask for such evidence.

Most would argue that a very significant evaluation deficit exists in state and federal perinatal programs, though many realize how important this information is. More and more often, programs are required to account for their funding. This is one of the most difficult challenges faced when implementing publicly supported programs.

Better evaluation components need to be designed for several reasons:

- Better data is needed to calculate the level of unmet need. If new publicly-supported programs for pregnant women are to be implemented, knowledge about who and where the women most in need are must be obtained.
- An ability to incorporate health status measures into planning is needed to assure quality. Measuring the health status of women who are served can determine whether these women are receiving the quality of care they need.
- In the areas of equity and fairness of care, a great deal more data is needed to describe the services needed by particular ethnic and age groups.
- In the area of cost, better qualitative and quantitative information about the effectiveness of interventions is needed. People are seeking findings, conclusions, summaries, and results in programs where valuable, scarce resources are expended.

Program evaluators stress how important it is to build an evaluation component into programs from the start. State and federal agency officials are urged to begin thinking about outcome evaluation at the time of implementation. It is very difficult and less effective to try to measure the impact of a program if evaluation components are not built into it prior to implementation.

Program effectiveness is hard to determine for several reasons. One problem is self-selection. Randomization seldom exists in publicly supported programs. For

example, it is often not feasible to randomize pregnant women into experimental and control groups, as can be done in smaller scale statistical evaluations. Ultimately, this can result in a selection bias. In other words, the women who seek out services from a WIC program or a health department prenatal program may be more motivated to begin with and may have done well without the program.

Arkansas and North Carolina are two states that have been actively evaluating maternal and child health programs for several years. They have employed statisticians who specialize in MCH programs. Both states have found it advantageous to fund a full-time position in the health department dedicated solely to evaluating MCH issues. Their evaluations match health program data files to vital records, particularly birth certificates, to evaluate prenatal care programs. Evaluators have matched Medicaid data, WIC data, and health department prenatal care records to birth certificates to enable several types of evaluations.

Arkansas and North Carolina decided early on to use birth certificates to match with other information about the program for several reasons. One advantage is that birth certificates contain a variety of information about pregnancy history, prenatal care, education, and birthweight. The program records have frequently been used only as a yes-or-no indicator (i.e., was the person in the program or not?). Another advantage of matching with birth certificates relates to the need for comparison. It is almost imperative to have a comparison or control group for evaluation, and the unmatched birth records can be used for this purpose.

Other states also may want to use birth certificates for matching purposes in their evaluation programs. As of 1989, the U.S. Public Health Service has developed a new birth certificate that will enable states to perform data matches more easily. The exact month, day, and year of the mother's birth will be included on these new certificates. Also, the mother's complete current name will be used on the certificate, rather than just her maiden name. The new birth certificates should significantly simplify the process of matching records.

Useful information can be obtained by linking program data files to births. North Carolina has used this data linkage to evaluate several projects. The first evaluation measured the effect of the WIC program on birthweight. The first step to accomplish this data linkage involved matching the Medicaid records to the birth certificates. This gave the analysts a comparison group of poor women. It would not be accurate to compare women on WIC with all the other women in the state, many of whom are not eligible for WIC. By using Medicaid as the first match, the state is then able to generate a subcategory of poor women and compare program outcomes within that group.

Through the data, North Carolina has been able to show a significant difference in birth outcomes for both white and non-white women participating in WIC. The Medicaid women not on WIC had a rate of births under 1,500 grams nearly three times that of the Medicaid women who were on WIC. However, analysts are quick to caution against making the conclusion that the WIC program alone is responsible for this difference. There are other factors that affect birthweight besides WIC participation.

Another evaluation that has been performed by the state linked both the Medicaid and Public Health Department records to the birth certificates. It compared low-birthweight rates of Medicaid women receiving care from public and private providers. Studies showed that the incidence of low birthweight were lower for Medicaid women receiving care from public providers. This is partly because prenatal patients at the health departments are more likely to be on WIC.

In addition to these activities, North Carolina has a proposal to evaluate the Baby Love program, the state's newly expanded, comprehensive perinatal program. The state plans to match the Medicaid-paid claims to the birth certificates in order to identify Medicaid births. By matching the health services information system records with the birth certificates, an identification of which Medicaid women receive their prenatal clinic services at public health departments can be made. The third match will be to the care coordination pregnancy outcome report. (This record is filled out by the client's care coordinator.) This can identify which women received care coordination services through the Medicaid program. Within the Medicaid births, a cross-tabular comparison of the four groups can be made (i.e., receives prenatal care at health department/does not receive prenatal care at health department/receives care coordination/does not receive care coordination).

After the four groups of births have been identified through the matching process, the state plans to compare the following information: percentage of births less than 2,500 grams, percentage of births less than 1,500 grams, and rate of infant mortality. North Carolina also intends to match back to Medicaid-paid claims to look at neonatal and infant Medicaid costs for the babies who fall into the four categories. Through this, a cost benefit analysis can be completed. Additionally, the state plans to add the WIC prenatal participation as another variable. Realizing how important it is to control for other risk factors besides program participation before making conclusions about observed differences, the state does have statistical methods for controlling for other risk factors. This information will be incorporated into the outcome evaluation.

Arkansas also has designed its evaluation protocols so that multiple measures can be made. Matched data files are enabling the states to track the increases in percentages of births to Medicaid-eligibles (both statewide and by county), and to track births by eligibility category (OBRA-86, AFDC, medically uninsured, and other non-Medicaid). Other important data are being gathered to evaluate the state's presumptive eligibility program and, in particular, the proportion of women who gain full Medicaid-eligible status subsequent to becoming presumptively eligible.

Conclusion

States adopting new perinatal programs must be sensitive to designing evaluation systems in the beginning of the process that will measure impact. For states in the initial phase of evaluation development, statisticians have a few suggestions:

- **State agencies must decide who will be in charge of the evaluation program.** Since Medicaid owns its own paid claims data and health departments own vital records data, the decision should be made initially

who will be responsible for conducting the evaluation, what questions will be addressed, and who will fund the evaluation.

- **Measuring the ratio of low-birthweight infants is preferred over measuring infant mortality.** Infant mortality has a longer delay before any data can be reported or compared. Low birthweight, on the other hand, can be reported immediately after delivery. Low birthweight also has the statistical quality called power. Because low birthweight is a more frequent event than infant death, rates or percents will have larger numerators. Therefore, these measures will have less statistical error.

Arkansas and North Carolina are only two of the states meeting the challenge of evaluating new programs' impact. As programs aimed at preventing the incidence of low birthweight and infant mortality continue to evolve, so will evaluation systems to measure effectiveness.

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III

BUILDING INTEGRATED PROGRAMS

"Since the passage of OBRA-86, forty-four states have taken this very golden opportunity to enhance coverage for mothers and children. Even more exciting, however, is the fact that the impact of this law has gone beyond expanding eligibility. It has created among state governments a new sense of cooperation in putting together comprehensive reforms to strike at infant mortality. A better system of health care for mothers and children is evolving across this country. . . .

"I believe that throughout this conference, we have to discuss not only the topic of improving state programs for pregnant women and children, but also one of the very oldest and newest questions in American politics: should this country have a national family policy? . . .

"The government is not a savior, yet the government cannot be a spectator, either. The first goal of a national, state, and community family policy should be to help parents succeed, and when they fail, to save as many children as we can. . . .

"I often like to quote a book by Robert Fulghum entitled, All I Really Need to Know I Learned in Kindergarten. *The lessons he speaks of, lessons which we all learned early in life, have a fascinating relevance to all of us that work on public programs and policies. The things we learned in kindergarten, he says, include: share everything; play fair; don't hit people; clean up your own mess; say you're sorry when you hurt somebody; live a balanced life; learn some and think some; sing and dance; work and play; watch out for traffic; hold hands and stick together; and finally, be aware of wonder. Oh, how we need to take these simple lessons from the sand pile into our offices today as we look at formulating policies and programs for the people we serve.*

"We must work on that sense of wonder, that sense of allowing people to dream, to dream about the future and that of their children. We must work to make sure parents can impart that wonder, impart their dreams to their children, and that those children can then carry those dreams into a ripe old age.

"If we do these things, the economic future of America will be insured. People will pursue their self-interest and they will continue to triumph the way we have for so many years. But if we continue to neglect the basic human needs of our people, our families will show the strain and our country will begin to shrink."

Carol Rasco
Special Assistant to Governor Bill Clinton of Arkansas
March 29, 1989

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State Program Coordination and Collaboration

In order to implement successful infant mortality initiatives, state Medicaid agencies and Maternal and Child Health programs are having to learn to work together. Often, a history of noncooperation makes such collaborative efforts difficult. This atmosphere exists primarily because of the different perspectives and philosophies of the two agencies. Overcoming these barriers is the first step to building a cooperative and coordinated effort. States that have made the most progress in addressing the issue of infant mortality invariably have broken down many of the barriers between Medicaid and perinatal and child health programs to build more effective relationships.

Michigan, North Carolina, and Utah are three states that have been successful in establishing new perinatal programs, due in large part to effective relationships between multiple state agencies. Yet these states, as well as others, have had to struggle to overcome a history of differing perspectives and philosophies between Medicaid and MCH agencies. The most common of these perspectives is a view of Medicaid as a program that focuses on auditing and cost containment and that is more exclusive than inclusive, in regard to both client and provider participation. Medicaid also is viewed as having little concern for the standards of care and quality assurance. On the other hand, many in Medicaid view Maternal and Child Health staff as "bleeding hearts," forever wanting to throw money at problems without regard to accountability.

What has enabled these states to initiate a collaborative endeavor? Michigan, North Carolina, and Utah have all learned that the first step is understanding each other's program goals and limits and learning to respect each other. Perhaps most useful is an understanding of four general dispositions contained in Medicaid:

- Medicaid looks for standardized ways to do things. Because of the volume of services, persons, and providers Medicaid agencies deal with, they look to automate as much as possible. Consequently, Medicaid has trouble looking at individualized service.
- Medicaid programs are driven by the politics of the state, mainly because it is often the single largest program of a given state's budget. On one hand, health care costs are eating up a larger portion of the state government pie each year. But on the other hand, payment rates generally are woefully inadequate, often leading to provider dissatisfaction. There is frustration among lawmakers who want to know who is going to halt this runaway train.

- Medicaid has to deal with contractors who want to make money off the Medicaid program by saving the program money. Medicaid directors, accustomed to being asked to give things, often become beleaguered, defensive, protective, and leery.
- Medicaid has a partnership with the federal government. Authorized by federal statute, the program is administered by the states. All aspects must comply with federal rules and regulations even when federal direction is unclear. Consequently, Medicaid officials spend a great deal of time worrying about federal audits.

Once public health officials began to understand these predispositions, Michigan, North Carolina, and Utah were on the road to building the foundation for a working relationship.

Medicaid officials also were forced to consider the constraints under which MCH programs operated, and to become sensitive to their administrative mind set. MCH agencies have historically operated with a great deal of flexibility and freedom to provide services in whatever way they feel is most effective. Gaining respect for MCH involved recognition on the part of Medicaid officials about the extensive service delivery experience possessed by MCH agencies as well as an understanding of how MCH conducts business. Aspects of the MCH program that are particularly useful to understand include the following:

- Federally, MCH is funded by a single, finite block grant. In addition, other sources of funding include state and local monies. Monies can be used to provide services for as long as money is available.
- MCH typically relies on a cadre of providers, both public and private, either located in local health departments or the private sector, to deliver services. These providers are known and trusted to give high-quality services.
- State MCH agencies set up objectives, then feel confident turning over money to the local providers to meet these objectives.
- State MCH agencies often feel their role is to fill gaps in service that Medicaid is unable or unwilling to provide.

Understanding these aspects of how MCH operates can often facilitate the relationship between Medicaid and MCH agencies.

As special initiatives continue to grow, roles and relationships between programs are evolving. Medicaid is getting more involved in protocols of care. Maternal and Child Health agencies are getting involved in third-party billing. The following discussion focuses on how these three states came together in a collaborative and cooperative way.

The North Carolina Story

North Carolina's perinatal initiative, the Baby Love program, was implemented October 1, 1987. Designed and co-administered by the Division of Medical Assistance (Medicaid), the Maternal Child Care Section of the Division of Health

Services, and the Office of Rural Health, Baby Love had its roots in three developments:

- Infant mortality in North Carolina had reached an alarmingly high rate.
- The state realized that Medicaid had to shoulder some of the responsibility for the infant mortality rate and do more. Too many indigent people were not qualifying because of income limits, resource tests, or other reasons. Of those potentially eligible, too many were discouraged by the eligibility system. And when clients were eligible, they could not obtain certain components of care because services were not covered, they did not know about them, or they could not get to the source of care.
- The OBRA-86 legislation allowed for the expansion of eligibility for pregnant women. For every dollar of state money spent, two dollars of federal money could be used to address the problems of infant mortality and uncompensated care given by hospitals.

To address these developments, the state's Indigent Health Care Study Commission recommended that approximately $6 million be transferred from the state Maternal and Child Health program to fund Medicaid expansion. This expansion consisted of Medicaid coverage of pregnant women and children up to the age of two at or below 100 percent of the federal poverty level. Furthermore, the expansion is to continue each year for children up to the age of five. In addition, Medicaid was given the authority to cover case management services, commence the presumptive eligibility option, waive the resource test, and initiate an outreach effort. The legislation was adopted in August 1987, with an implementation date of October 1 – allowing only three months to set up a new system.

Medicaid had the funds for the new expansions, yet relatively little time to implement a statewide effort. Although organizationally Medicaid and Maternal and Child Health are housed under one umbrella agency called the Department of Human Resources, their relationship historically had been one of benign neglect. Before this new legislation, both agencies felt they shared neither common goals nor a common client population. However, they soon realized they did share the same goals but had never agreed on the methods for accomplishing them. It did not take long for Medicaid officials to realize that although they had the money, Public Health had the service delivery expertise. With this in mind Medicaid approached Public Health for an initial meeting.

To put it mildly, MCH officials were quite upset with the transfer of money out of their budget. Public Health officials felt that state money that had previously been used to fill gaps in the service delivery system and improve access to care for indigent pregnant women and young children not previously eligible for Medicaid, was gone. They were left with little choice except to work directly with Medicaid to ensure that the provision of comprehensive, continuous care for the maternity population would continue.

At their initial meeting, Medicaid officials assured Public Health officials that they were aware of their good infrastructure and wanted them as an equal partner in this endeavor. Public Health – with twenty representatives to Medicaid's two – was shocked to hear not only that Medicaid was concerned about the problem of

infant mortality but also that it recognized Public Health's expertise in developing programs for pregnant women and young children. Despite the lack of a previous relationship, the two agencies were able to decide on an operational framework for the Baby Love program at this initial meeting. The framework established consisted of the following aspects:

- Develop a statewide outreach campaign and system directed toward clients, other state and local level organizations, and local providers.
- Improve participation in the program – especially noting the historically low participation in Medicaid – by improving the enrollment process, beginning with presumptive eligibility.
- Implement case management statewide to ensure delivery of comprehensive care.
- Initiate an outcome-oriented quality assurance program.

As the two agencies began to work on the program, the relationship between them grew from one of tentative agreement to a solid commitment to coordinate activities. One of the critical factors to the program's success was a very strong commitment that this should be a major initiative of staff in both agencies. This allowed the players in MCH and Medicaid to put everything else on the back burner and focus fully on this effort for the three months.

The state was able to design and implement the program in the three months afforded to them through a variety of strategies. Work committees were formed to look at existing agency committees that could be converted to assume these new responsibilities. These committees also looked at other agencies and individuals that could be added in order to begin a broad participation in this effort. The manual for the maternity care coordinators was written with input from state and local staff. As part of the implementation process, joint visits by MCH and Medicaid were made to local agencies. The purpose of these visits was to learn from the local experience – to find out what their problems were, what could be done to improve the program, and what their successes were. This information could then be shared with other counties.

Through these visits and constant communication with local, regional, and state staff responsible for implementation, two major problems were identified early on in the program. Not surprisingly, the first was that difficulty existed in establishing cooperative working relationships between local health care agencies and the county departments of social services, which has responsibility for granting Medicaid eligibility. Historically, there had been very little cooperation between the local agencies, as there had been at the state level. Yet the success of this program was directly dependent on such cooperation. Health departments and primary care centers had to establish referral protocol and follow-up mechanisms with the county departments of social services to ensure that clients would become certified after being identified as potentially eligible for Medicaid. Social services staff had to learn about the importance of prenatal care in helping to reduce infant mortality. They had to understand the role they could play as part of the team effort.

The state overcame this problem by demonstrating coordination at the state level. Additionally, technical assistance was provided by state staff; joint training sessions of local, regional, and state departments of social services and health care agency staff were held; encouragement was offered through the outstationing of eligibility workers at clinic sites; and meetings to address common problems were held on an ongoing basis.

The second major problem revolved around the lack of up-front funding. A frustrating "catch-22" was created whereby new services could generate new Medicaid revenues for public health providers, but without start-up funding providers couldn't afford to hire new staff to start offering the services. Even when there is a strong commitment to the program, understaffed and overextended health departments are experiencing difficulties in assuming these new responsibilities. In many instances, local leadership is the key factor in the county's transition to Baby Love. The state is continuing to struggle with this problem, though resolution has been achieved in part through technical assistance and sharing of information among counties. Also, a grant proposal was recently developed to create a revolving loan fund to provide local agencies monies to hire care coordinators.

The success of this collaborative effort between Medicaid and MCH is evidenced by the program's current status. Since implementation, actual enrollment has reached 110 percent of the original estimated participation for pregnant women, and 56 percent of the originally estimated children have been enrolled. Eighty-three counties out of 100 are currently providing maternity care coordination services. The service delivery system includes local health departments, rural health centers, Community and Migrant Health Centers, and Indian health centers. Seventy-three agencies have become qualified providers to determine presumptive eligibility. Finally, more than 155,000 Baby Love brochures have been distributed and more than 256 agencies are participating in a statewide resource referral network. This data reflects that Baby Love is impacting the lives of low-income pregnant women.

The Michigan Story

As in North Carolina, officials in Michigan recognized early on the opportunity to harness federal dollars offered through the OBRA-86 legislation. By channeling new money received for a Public Health-run state prenatal care program to Medicaid, the state doubled a $9 million program, gaining about $18 million worth of resources.

With these dollars the state has implemented several new programs aimed at improving access and delivery of prenatal care. These new programs include:

- **Maternal Support Services Program**. This program offers nonmedical support services to pregnant women.
- **Shortened Medicaid application form**. Michigan has streamlined the Medicaid application from a twenty-eight pages to four pages. The new applications are being filled out primarily by staff in the forty-eight local health departments in the state.

- **State-funded prenatal care program**. Michigan has maintained a residual state-funded program that covers women below 185 percent of poverty who do not qualify for Medicaid, despite the broadened eligibility criteria. Immediate coverage is guaranteed to providers through one or the other programs.
- **Outreach program**. Medicaid financing is available on a 50-50 administrative matching basis for paraprofessional outreach workers to help do case finding of pregnant women. Local health departments are also paid through this match to enroll women in the Medicaid program.

One revealing aspect of Michigan's effort that evidences the collaborative relationship between the state Medicaid agency and the Bureau of Community Services (the MCH agency) is contained in their budget initiative. The state has accomplished a mixture of funding in each agency's budget, which takes into account the vulnerabilities of the two programs. For example, money that was in MCH's budget to pay for prenatal care for women who do not qualify for Medicaid even after the expansion, has been transferred to Medicaid. This takes advantage of the fact that Medicaid is a fiscal intermediary and allows physicians to send their bills to one place for reimbursement. Also, since it is a limited amount of money, if more people end up in the state-funded program than anticipated, it becomes a social services problem – not a public health problem. It protects MCH if eligibility barriers prove too formidable. The state also proposed a Medicaid vital records data linkage project that would allow the state to tie information that comes out of the Medicaid billing system to birth and death certificate vital records information. This would allow the state to track what is happening to women who participate in the program. State MCH staff are getting paid through a Medicaid administrative match for prenatal care activities as well as data collection activities.

The state has identified several factors that helped spur activity to initiate a coordinated prenatal care endeavor. As in North Carolina, the first was the high infant mortality rate. Significant public pressure sensitized both agencies to this issue, making them receptive and responsive to taking a very proactive approach to the opportunities that the new federal legislation brought. Another factor was a study that proved in Michigan that a disproportionate share of the Medicaid population experienced infant mortality. Around that same time, a seventy-eight-person task force in Michigan convened to look at the infant mortality issue and recommend achievable objectives for both state agencies.

Importantly, MCH recognized that its goals would have to be accomplished using the Medicaid program as a primary vehicle – Medicaid had more potential for financing services. Although the health department did have a long relationship with Medicaid through the Early and Periodic Screening and Diagnostic Testing Program (EPSDT), it had its pros and cons. Collaboration on EPSDT created some familiarity and a basis for talking to one another, yet many perception-based barriers persisted. Overcoming this history has enabled public health officials to realize that they must operate within the constraints the Medicaid program faces.

Another critical factor in developing a successful prenatal care program in Michigan was the involvement of outside advocacy groups. The Michigan Council

for Maternal and Child Health has been very effective in working in a proactive way with Medicaid and Public Health, by helping promote their messages to the legislature, to the Governor's office, and to the media. The organization also uses its advocacy when both agencies are getting lost in the bureaucratic thicket to turn attention back to the consumers' perspective. That pressure has been useful in resolving some of the conflicts between the two bureaucracies.

Through these coordinated efforts, the state has successfully implemented a statewide prenatal care program that is serving more women more efficiently.

The Utah Story

Utah also has embarked on a significant perinatal initiative. The state has expanded eligibility to 100 percent of the federal poverty level for pregnant women and children to age one. In addition, Medicaid is now covering perinatal care coordination and other enhanced prenatal services such as nutritional counseling and assessment, psychosocial assessment and counseling, and health education. The state also has a statewide media outreach campaign. To address eligibility barriers, presumptive eligibility has been adopted and eligibility workers have been outstationed at clinic sites. To provide these new services, the Division of Family Health Services (MCH) and the Division of Health Care Financing (Medicaid) have joined together in a collaborative effort.

When the state decided to improve and expand prenatal services in Medicaid, they had the unique advantage of having a director of Family Health Services who previously had served as acting director of Medicaid for a short period of time. This had afforded him the opportunity to learn about the problems with which Medicaid staff have to deal, how they think, and the kinds of priorities they are trying to balance against each other. This made that initial step of overcoming historical perspectives a little easier.

Similar to the case in Michigan, it was public health that initiated the new perinatal program in Utah. When public health officials approached Medicaid to expand services and access, MCH had already secured new budget authority to drive the program, garnered through a three-cent increase in the cigarette tax. MCH also had good data to make a compelling argument of why Medicaid needed to be involved. By comparing birth and death certificates with Medicaid claims, MCH proved that birth outcomes were as poor in Utah in the Medicaid population as they were in other states around the country struggling with the infant mortality problem. Once these data were presented to Medicaid, an infant mortality initiative became a priority for both agencies.

The fact that all the resources needed to implement a statewide perinatal initiative are housed in one umbrella agency, the state department of health, has been key to the success of this collaborative effort. Once Medicaid and MCH directors agreed on the new program, no other third party needed to be included. This helped keep the confusion to a minimum and allowed things to move fairly quickly.

Other factors also contributed to the state's success. One is that both sides agreed to adequate resources. They were in agreement about not only the number of dollars needed, but also the importance of using good people who had the appropriate backgrounds to make it work. In addition, involvement and financial support from the business community and from the media to get the program well known and operating played a significant role in the success of the program. (See Chapter 2, "Targeting Outreach Effectively.")

One unique aspect of the initiative that illustrates the trusting relationship the two agencies have built is the financial arrangement. Both agencies estimated that the Medicaid utilization rate would increase by 8 percent during the first year of the expansion. MCH agreed to pay for the care of any additional women they were able to bring into the program over and above the 8 percent. After those women deliver, MCH is billed for any services above that utilization rate. In the first year, the Medicaid utlization rate for pregnant women increased by almost 16 percent. Consequently, MCH is paying for the difference between the 8 percent and 16 percent.

The second part of the financial agreement involves the enhanced services now offered. When the global Medicaid fee was increased, the amount calculated for the cost of the new services was not included. These costs are paid for using state MCH dollars, which are then matched by Medicaid for all pregnant women in the Medicaid program. Both agencies find the arrangement fair. MCH spends only what the actual expenditures are within the Medicaid program. The rest of the state money can be used to help health departments get up to speed, either for front-end money to serve women not eligible for Medicaid or to hire additional staff needed to produce a more fair and expanded prenatal program.

The financial arrangement has worked so well for the two agencies that they have agreed in principle to another similar proposal. If the state can show that it has saved Medicaid the expense of paying for a certain percentage of low birthweight babies and calculate that cost, the money saved will stay within the prenatal effort in the Medicaid and MCH programs. This money can then be used to further expand global fees and/or expand eligibility to over 100 percent of the federal poverty level. If this can be done the data can also serve as an evaluation tool.

The program has not been without its problems, however. There was initial reluctance on the part of some Medicaid staff to expand in this area while cutting the program rather dramatically in other areas. The state was facing a significant budget problem when MCH lobbied and got passed the cigarette tax that paid for the prenatal care expansions. The decision to use this money to provide enhanced services to Medicaid clients was made only after OBRA-86 legislation passed. In the meantime many other Medicaid services in Utah were being reduced.

Other problems occurred in the area of eligibility. At the time of expansion, the social services department in Utah was in the midst of a major system change. It was initially reluctant to start making determinations by the target date for this new population since it was not built into the new system. However, after a "friendly

ultimatum" by Medicaid, social services did come on board rather than have the eligibility intake system contracted out.

Conclusion

Michigan, North Carolina, and Utah now have significant statewide perinatal programs. These programs would not have been possible without the coordinated and collaborative effort by the states' Medicaid and Maternal Child Health agencies. Though the development and implementation process involved compromise and understanding, the results have been impressive. Not only do these states have premier prenatal care programs, but the two agencies have gained a mutual respect for, and an important relationship with, one another.

Panelists:

Dennis Williams
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North Carolina Maternal and Child Health

Kevin Seitz
Director
Michigan Medicaid

Denise Holmes
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Utah Division of Family Health Services

Moderator:

Ian Hill
National Governors' Association

IV

CHARTING A COURSE FOR THE FUTURE

"During the 1980s, I would argue that the single most important legislative initiative on behalf of [pregnant women and children] was the 1986 Governors' proposal to de-couple Medicaid from the income assistance programs.

"Of the 37 million uninsured Americans, one-third are children. Four million of these 12 million children are under the age of six, and the majority of these children have working parents. The number of uninsured children has increased by 13 percent over the last five years and the trends with respect to employer-based insurance are not what we would want them to be – they are downward rather than upward. Four million American children now live below the poverty line. They receive 40 percent less physician care than their insured counterparts, and one-half as much hospital care as their insured counterparts. Seven million children do not receive routine medical care at all. Forty percent of children in the preschool age category are not adequately immunized despite the fact that. . .there are enormous cost savings associated with early immunization. . . .

"There is broad-based agreement about the impediments to health care facing these families. Perhaps more importantly, there seems to be very broad-based consensus about the necessary remedies that we can all engage in to try to correct some of these problems. The debate over the United States' trade policy, interestingly enough, has made it abundantly clear that in the coming century, the United States is going to need each and every one of these children if it is to compete effectively in a very competitive world market, one that is increasingly dependent on a skilled workforce. You can't continue, year after year, to lose one in five children to poverty. And you can't continue, year after year, to fail to extend to children the basic health services that they require. . . .

"Let me urge you to take advantage of this [congressional] enthusiasm in Washington right now, because there is no guarantee that this issue will remain at, or near, the top of the federal funding agenda in the future. Grab the brass ring now, even if it means that organizationally it's a little bit confusing, a little bit chaotic, and maybe not as smooth a transition as you would like."

Marina Weiss
Chief, Health and Income Security Section
Senate Finance Committee
March 31, 1989

9

Improving Integration Between WIC and Medicaid

As states explore strategies that lead to better birth outcomes, it is essential that the Special Supplemental Food Program for Women, Infants, and Children (WIC) be better integrated with other programs to provide comprehensive care to pregnant women and children. WIC is universally regarded and respected as one of the most successful and cost-effective programs that benefit low-income women, children, and families. But unfortunately, integration that should exist among WIC, Medicaid, Maternal and Child Health, and Public Assistance is not always achieved.

The WIC program provides supplemental food, nutrition screening, and education for pregnant and postpartum women, infants, and children under age five. Applicants must satisfy two eligibility criteria in order to participate: they must be at nutritional risk and they must have family incomes below 185 percent of the poverty level. WIC is federally funded but is not an entitlement program. In fiscal 1989, WIC was funded at $1.9 billion. With those funds, as well as state funds that are contributed in sixteen states, 3.8 million people are currently served. However, that group represents just under half of all the pregnant women, infants, and children who are potentially eligible for the program. The program is administered on the federal level by the Food and Nutrition Service in the U.S. Department of Agriculture. On the state level, WIC is usually administered by health departments, and on the local level by health or social service agencies.

In 1987, the Center on Budget and Policy Priorities instituted the WIC/Medicaid project. The project's purpose was to ensure that pregnant women who were already participating in the WIC program be referred to Medicaid because, as a result of the OBRA-86 and OBRA-87 expansions, it was likely that those women were now eligible for Medicaid. State-specific fact sheets were developed and distributed with information on eligibility limits for pregnant women, infants, and children under age five. The fact sheet not only was a valuable screening tool for local WIC agencies, but also served as an introduction to the Medicaid program.

Data from several sources pointed to the need for such a project. A survey of income and program participation conducted by the Census Bureau showed that in 1986, half of all households with one or more children under four years of age who were participating in WIC also received Medicaid benefits. This is not surprising because before OBRA-86 expansions, eligibility for WIC was set at much higher income levels in most states than income eligibility for Medicaid. What is surprising, as well as disturbing, is that of those on Medicaid and potentially eligible for WIC,

only one-third of the households with children under age four were participating in the WIC program.

The Southern Governors' Association (SGA) offered additional information pointing to the need for referrals between the two programs. As part of a survey on the relationship between Medicaid and WIC conducted by SGA in 1987, states were asked to report on the portion of WIC participants who were also participating in Medicaid. In the four states that were able to provide those statistics, only 25 percent to 30 percent of WIC participants were also on Medicaid.

Recent studies illustrate the irony of this unfortunate situation. A 1988 study in Missouri examined Medicaid participants who receive WIC services. The 1982 study showed that for every dollar spent on WIC, approximately 49 cents in Medicaid costs were saved during the first forty-five days of life. Moreover, in order to complete the Missouri study, WIC and Medicaid records had to be linked. Through this data linkage, it was found that in 1980, only 25 percent of the pregnant women participating in Medicaid in Missouri were also receiving WIC benefits. In 1982 the figure had gone up to 36 percent. A recent match of WIC and Medicaid records shows that the figure has risen to 54 percent.

The increase over the years is encouraging. However, the fact remains that approximately half of the pregnant women in Missouri who are receiving Medicaid benefits are still not on the WIC program. Although some of these women may not qualify for WIC if they are not determined to be at nutritional risk, all of them are financially eligible for the WIC program. The low level of dual participation is particularly disturbing because Missouri is one of the only states that can match those records and is one of the first states to place an emphasis on dual participation. The figures in many other states are probably even lower.

These statistics demonstrate that there is a real need to increase referrals between the two programs. Recognizing this, Congress passed legislation in 1988 that adds Medicaid to the list of programs with which WIC must coordinate. Similar proposals are included in current infant mortality and child health initiatives. These proposals would require state Medicaid agencies to inform pregnant and postpartum women, infants, and children under age five who apply for Medicaid benefits about the WIC program.[5] Once referrals are made, states will be responsible for making sure the women and children actually get enrolled and receive the services.

Several states have already initiated successful efforts aimed at increasing referrals between the WIC and Medicaid programs. States recognize that if they can match records to generate statistics, they also can match records in order to generate referrals. One example is Missouri, where a system has been developed whereby Medicaid participants who are not receiving WIC are contacted by mail. The clients' names are sent to the local WIC offices for follow-up contact.

As data systems become more sophisticated, referral services will increase. By building in the referral component initially, dual participation can become a routine operation of the system. This will ultimately guarantee that participants are referred to other programs.

Recently, WIC programs have worked on cost containment efforts by obtaining rebates for infant formula supplied to their clients. As a result, more funds are

available to serve additional participants in some states and efforts are needed to reach potentially eligible WIC participants. However, if those states conduct more generic outreach campaigns, thereby bringing women in for prenatal care and other services they need in addition to WIC, the campaigns can be much more effective. For example, in Utah the Baby Your Baby campaign has had a positive effect on WIC enrollment. The campaign message is very simple, telling women to just come in if they are pregnant. It does not talk about eligibility guidelines or specific programs. This is a good concept for two reasons: clients can be tracked once they enter at a specific point (for example, a toll-free hotline), and funds that are designated for one program can be used to invite participants into several other programs.

Ohio is another state that has instituted a policy to increase referrals between Medicaid and WIC. Information was provided to local WIC staff about the Medicaid program. In addition, the state held training sessions to ensure that the staff understood this information. Through these efforts, the state has greatly increased the likelihood that referrals will be made.

Another important strategy to improve local agency coordination is to get information about the location of local WIC clinics to workers who take Medicaid applications. The Center on Budget and Policy Priorities will be publishing a listing of local WIC agencies for all states. The Center hopes to make this information available to all Medicaid agencies. Medicaid staff will then be able to refer their clients to WIC and inform them where to go to apply for WIC benefits.

Vermont is developing one of the most exciting programs to ensure that referrals are made and that those referrals result in services being utilized. The state is creating a one-page application that pregnant women can use for both Medicaid and WIC. It is the responsibility of the program that takes the application to get the application to the other program. In other words, a pregnant woman is not handed a piece of paper and told, "Take this to the Medicaid office," or "Take this down the hall," or "Call for an appointment." The coordination is done by the program staff themselves. Also, when the woman applies – no matter which location is used – the date of the application is used for both programs in determining eligibility.

Even though the next logical step in the process of ensuring dual participation would be the ability to make financial eligibility determinations jointly, this is not yet possible. Each program has separate financial eligibility rules. On the federal level the programs are administered by two different agencies – the WIC program by the Department of Agriculture, and the Medicaid program by the Department of Health and Human Services. Consequently, problems exist. For example, a pregnant woman on Medicaid is counted as two family members – the woman and her unborn child. However, for the WIC program that woman is counted as a family of one. There are also certain income deductions allowed for Medicaid that are not allowed in the WIC program. Another problem is that for part of the year the two programs use two different federal poverty guidelines. The reason for this is that although both the WIC and Medicaid programs rely on the same federal poverty income guidelines, the Department of Agriculture and the Department of Health and Human Services publish the guidelines in *Federal Register* notices at different

times. The Department of Health and Human Services generally publishes its guidelines in February and states may use the new guidelines any time after publication. However, the Department of Agriculture publishes its guidelines later in the year and requires that WIC agencies use the new guidelines beginning July 1 of each year.[6]

Fortunately, some promising efforts are on the horizon to resolve some of these problems. Reauthorizing legislation for the WIC program is expected to include a new definition for pregnant women so that they will be counted as a family of two. Another legislative change would automatically make pregnant women, infants, and children under age five who are Medicaid recipients financially eligible for the WIC program.[7] However, legislative changes are not translated into operational changes overnight. Any new federal legislation will require significant state efforts between Medicaid and WIC to streamline the process.

As Medicaid programs continue to expand because of mandates from Congress and initiatives in the states, more women, infants, and children will enter into the program. It is likely that many of these new eligibles also will need WIC services. Simultaneously, newly available WIC program funds create an opportunity to bring in more women, infants, and children who may also be in need of Medicaid services. There is no better time to improve coordination between these two programs.

Panelist: **Laura Summer**
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Center for Budget and Policy Priorities

Moderator: **Ian Hill**
National Governors' Association

10

Improving Coverage of Children and Adolescents

As state programs continue to expand and improve Medicaid coverage for pregnant women, more effort will need to be directed toward ensuring that the infants who are born to these women can also access and receive the care they need. Since the passage of OBRA-86, states have pursued numerous and diverse initiatives aimed at expanding and improving prenatal care systems. To date, however, little attention has been paid to the other half of the equation – the children. Already, there have emerged several indicators that show children living below poverty are not becoming eligible for Medicaid and are not receiving adequate health care services.

The first indicator of this problem relates to eligibility thresholds for Medicaid. While nearly all states have expanded coverage of pregnant women living below poverty, and more than one-third have used optional authority to expand coverage to the fullest extent possible – 185 percent of poverty – states' efforts to enhance coverage of children has been mixed. As of July 1989, about one-third of the states had expanded coverage to the highest possible point – children between the ages five and eight. Another third were phasing in coverage of children between the ages of two and five. This leaves a final one-third covering children at the minimum – infants under age one.

Further, many of the structural innovations that have been pursued to streamline eligibility for pregnant women have not been permitted under federal law for children. For example, states cannot implement presumptive eligibility programs for children. Currently, the law does allow automatic eligibility for infants during the first year of life. During that time, providers are allowed to bill for services provided to the infant using the mother's Medicaid number *as long as the mother remains eligible*. However, since many of these infants are born to women who are eligible for Medicaid solely as a result of their pregnancy, the women and thus the infants are eligible only during the first sixty days after birth. Already, sixty days is proving to be an insufficient amount of time to get the child enrolled in Medicaid.

A second indicator of trouble can be seen when examining states' use of the EPSDT program. EPSDT has alarmingly low rates of participation in many state Medicaid programs. During the past three years there has been some increase in the participation of EPSDT, rising from 25 percent to 40 percent. However, the number of eligibles has grown 7 percent, indicating that this increased volume is slow. Seven states in the past year had screening ratios of over 50 percent but there were ten states that had ratios of 15 percent or less.

The EPSDT program is broken down into two age brackets for reporting reasons: zero to five years of age and six to twenty years of age. In the zero-to-five

range, there is a 59 percent participation rate. However, much of that is attributed to the fact that most of those screened are infants, who receive several examinations. In the six-to-twenty age group, the usage drops to only 13 percent. More than one-third of these examinations are identified as referrable conditions. Only ten states have ratios of 25 percent or more for the older group. For many reasons, states are still wrestling with what to do with this special preventive health component of Medicaid. What activities are important that should be done under the program? What priorities should be set by states?

There are two major reasons why states should be concerned about children's health issues – children's insurance status and children's health status. The proportion of low-income children with employer insurance dropped by about 25 percent from 1980 to 1986. One reason for this is the demographics of these children. Many are born into single-parent households and do not have access to employer insurance. Another reason is that employers' contributions toward health care coverage have dropped. There has been about a 30 percent drop in the number of employers who contribute to the full cost of their dependent coverage plan; many more are contributing only part of the cost. Many employers are now switching to a defined contribution system as opposed to a defined benefit system. By doing this, employers offer their employees the choice of buying several different benefits. For families that have seen their real wages drop over the last several years, choices may be made to use their wages to buy other necessities rather than dependent coverage. All these factors indicate that for poor children living in working households, insurance coverage is seriously lacking. Medicaid in the past has done a terrible job of covering these poor children as well. Before OBRA-86 and OBRA-87 legislation, it was not possible to get federal matching funds to offer services to low-income children who did not qualify for cash assistance. The number of uninsured children is going to continue to increase if the employer system continues to erode and Medicaid fails to grow to take its place.[8]

The health status of children is another reason states should be concerned about these issues. Because of inadequate national data reporting systems, an accurate measurement of the problem is difficult to establish. However, some indicators make it possible to assess children's health status. Child mortality data show that poor children are much more likely to die than their higher-income counterparts. Immunization status is another good indicator of access to basic primary services. Between 1980 and 1985 there was a drop for non-white infants in the number who had received full immunizations for polio and DPT (diptheria, whooping cough, and tetanus). In New Jersey and Boston, two studies of children born prematurely with serious problems show that socioeconomic status and access to basic services seem to have a separate and measurable impact on whether, by age four, a child has motor skills and other cognitive developmental skills that are age-appropriate. Another good indicator of access to health care is dental care. Utilization of this service is low among poor children.

One group of children that historically has been neglected with regard to health care is adolescents. States should no more abandon children when they reach the teenage years than when they reach age one or age five. Statistics show that this is one age-specific group in need of intervention. For example, the adolescent

mortality rate has increased 12 percent in the last ten years. Drugs, alcohol, homicide, suicide, and teenage pregnancy are contributing to this. The following figures further illustrate the need for intervention:

- In the United States, more than a million teenagers get pregnant every year, with almost a half million giving birth.
- One in five adolescents age fourteen to seventeen is a problem drinker.
- One in six high school students smokes daily.
- Nearly one in three students reports illicit drug use in the past month.
- Fifty-seven percent of high school students admit to being sexually active. Most wait an average of nine to twelve months before seeking prescription drugs for contraception.
- One in five adolescents is obese.
- Just one in three adolescents can pass a physical fitness test.

These figures are alarming. Yet many feel that adolescents are healthy individuals. Most lawmakers seem to be unaware of the severity of their problems. However, most states can attribute their high infant mortality rates at least partly to teenage pregnancies.

Fortunately, the health care needs of the nation's children are gaining more and more attention. Over the next year, several major bills will be introduced to Congress to address some of these issues, including:

- A proposal to mandate Medicaid coverage for all children under age eighteen with family incomes below 100 percent of the federal poverty level. This coverage would phase in beginning with children under age eight.
- A proposal to make it optional for states to offer annual periods of enrollment for children. If a child is found eligible for Medicaid in January 1992, for example, that child's eligibility need not be redetermined or reviewed until January 1993. This will stabilize coverage under the program and make it possible to retain more stable relationships between the child and the child's family and the health care system.
- A proposal to make it optional for states to extend coverage to children under age five with family incomes under 185 percent of the federal poverty level.[9]

Several states, however, are not waiting for federal legislation to extend health care coverage to their children. Minnesota is an example of a state that has taken the initiative to provide health care to children in families with low incomes. The Minnesota Child Health Plan, which has been enthusiastically received by the residents of the state, offers primary benefits to children up to age eight to families with incomes under 200 percent of the federal poverty level. The program was funded its first year through a cigarette tax and enrolled several thousand children. Currently, monies for the program come from the state general fund.

The majority of states, however, are unable or unwilling to provide health care for children not eligible for Medicaid. Because of this, many groups have advocated

on behalf of this vulnerable population. The Children's Defense Fund (CDF) is one such organization. This group has been active in trying to bring before Congress legislation to expand health care coverage for children. Specifically, the group would like to see some of the changes in policy that have been applied for pregnant women extended to children. For example, presumptive eligibility could be used to identify all children of pregnant women who are found eligible. The Children's Defense Fund also would like hospitals to ensure that the Medicaid enrollment process is initiated for the children of women who are discharged from their facilities. In addition, CDF has identified several strategies that could be initiated to improve the EPSDT program. These include:[10]

- States should use the comparability authority given under the program to provide all medically necessary care, not just those services required under the law.
- States should perform interperiodic screens. This option, available under federal law, allows providers to trigger an assessment and diagnostic and treatment workup in the case of a child who has a suspected abnormality outside of the regular schedule to provide enhanced benefits.
- States should ensure that all public providers have strong EPSDT programs, even those states using managed care arrangements.
- States should match up activities between health departments and education departments to identify children who are not grade-appropriate in school. There is a significant link between health problems and grade appropriateness.
- States should forge strong working relationships between Medicaid and health departments, school dropout prevention programs, education initiatives, and job training programs.

Integration of services is another important strategy that can be used to greatly enhance health care coverage of older children and adolescents. States must turn their attention to primary prevention and wellness; however, this can be accomplished only through the coordination of programs. Some strategies to integrate services include:

- The establishment of school-based clinics to provide health services to adolescents.
- The establishment of child health clinics that will provide EPSDT, WIC, MCH, and immunization services at one site and during one visit.
- The education of children from kindergarten through twelfth grade about wellness.
- Innovative uses of funds to benefit all children served.

In order to implement many of these initiatives, public health officials must take responsibility for making leadership understand how important the programs are. The country cannot afford to enter the twenty-first century where children are unhealthy and uneducated, with no motivation and no hope. The children are the leaders of the future; they must be treated as such.

Panelists:

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Joycelyn Elders
Director
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Moderator:

William Hiscock
Financial Policy Chief
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U.S. Health Care Financing Administration

11

Improving Services for Special Populations

States have made and are continuing to make huge advances in the area of prenatal care. Access has been widened, not only through expanded income eligibility thresholds but also through strategies to streamline the eligibility process. By the same token, services have been greatly improved. Care coordination for pregnant women has been implemented in many states. In addition, nonmedical support services are now being covered under many states' Medicaid programs. However, states are realizing that there are still significant subpopulations of pregnant women that present special challenges. Pregnant women who are substance abusers require special initiatives to reach and to treat. Similarly, homeless pregnant women are another group who require special intervention.

Substance Abuse and Perinatal Intervention

Substance abuse during pregnancy has escalated throughout the country, partly due to the current crack epidemic and the advent of new illicit drugs, and partly due to long-standing problems with alcohol and tobacco use. The number of babies born to drug addicted mothers has increased dramatically. Hospitals across the country are experiencing higher utilization in neonatal intensive care units because of drug dependencies among babies. Substance abuse during pregnancy, while it crosses all socioeconomic classes, seems to be a particular problem for Medicaid-eligible indigent women. The problem contributes directly to higher rates of infant mortality and low birthweight. It also jeopardizes the normal development of these infants and adds tremendous costs to states for high technical care in the hospitals.

States are beginning to face the challenge of serving the special needs of this population. It has been estimated that 15 percent to 35 percent of all pregnant women repeatedly abuse alcohol and/or drugs during pregnancy. Finding an effective strategy to care for this population is critical to ensuring that these women and their infants are served in an optimal manner. There is little doubt in anyone's mind that babies born to drug-addicted mothers are adding to the infant mortality rate.

Pregnant women who are substance abusers present special, more complicated problems than other hard-to-reach populations. Many of these women have an increased incidence of sexually transmitted diseases, have poor nutritional status, are infected with hepatitis, and exhibit increased rates of urinary tract infections. In addition, they often have serious obstetrical problems, including premature labor, premature separation of the placenta, and abnormal presentations at birth (e.g., breech birth). Babies born to these women frequently are low birthweight, have

small head circumferences, are premature, and are small for their gestational age. Further, these women are quite difficult to find and draw into treatment. Many are unwilling or unable to enter treatment on their own, either for their own addiction or for their pregnancy. Consequently, up to 75 percent of compulsive substance abusers do not seek any prenatal care. A factor that makes treatment even more difficult is that most are poly-drug users; that is, they abuse several substances simultaneously. Another problem is that, because of their lifestyles, these mothers are at an increased risk of being infected with life-threatening viruses, such as AIDS.

Martin Luther King Hospital in Los Angeles, California, has established a program to treat substance-abusing pregnant women. The obstetrical staff is involved in trying to decrease the numbers of low birthweight babies born to addicted mothers. They know that about 20 percent of all low birthweight babies born at the hospital are born to mothers who are known addicts. However, they suspect that many more of the mothers who give birth to infants with low birthweights are addicted gravidis or at least repeated substance abusing gravidis. To address this, the obstetrics division of the hospital has implemented a comprehensive program that includes an outreach component and is aimed at treating both substance abuse and pregnancy-related problems.

Because of the multiple problems presented by addicted pregnant women, it is felt that a medical center is the best facility for treatment. Many resources already located in a medical center do not have to be duplicated in order to provide services to substance abusers in a comprehensive manner. Through their work, the staff involved with the program have been able to identify several effective methods of treatment.

As mentioned earlier, most addicted pregnant women are poly-drug users. Therefore, to counsel these women the staff must know what substances are being abused. They have found that the most effective way to determine what drugs are being used is through serial random testing or screening of the mothers during pregnancy. The newly established comprehensive program at Martin Luther King Hospital, called "Project Mama," also includes a counseling component. Because of the increased risk of these women and their infants to contracting AIDS or hepatitis, the staff is trained to counsel the women regarding these risks. Pregnant women in the program are advised and given the chance to consent to an AIDS test as well. The hospital feels it is important that staff are trained to deal specifically with these issues.

One of the most encouraging and positive aspects of the program is the discovery that treating addiction in pregnant women is effective for both the woman and her unborn child. Instead of performing an emergency Caesarean for a fetus withdrawing in utero, which only adds to the already high number of low birthweight infants in intensive care nurseries, treatment can be provided to the addicted mother. When outreach is successful, the intervention can effectively treat both the mother and her distressed baby. This has the added bonus of being cost-effective as well. Premature babies, who would require costly neonatal care, can be kept in utero to develop normally if addicted mothers are reached and treated early.

Although this program and others around the country have identified several strategies that can intervene successfully in a substance abuser's pregnancy, one significant barrier to treatment still exists. It is believed that the only way to be completely successful in ending substance abuse during pregnancy is to remove the woman totally from her environment. Limited and costly hospital beds make this close to impossible in most circumstances. States are finding that not until an effective outreach strategy has been identified to find these women early and bring them into care, and not until a place to house these women during pregnancy is found, can comprehensive substance abuse and addiction treatment programs make an impact on their lives and the lives of their unborn children.

Health Care Needs of the Homeless

Pregnant, homeless women are another subpopulation that are contributing to high infant mortality and perinatal morbidity rates in this country. These women also require special initiatives if they are to be reached and drawn into care. As awareness of the homeless problem grows, so does awareness of the special health care needs of this population.

The Health Care for the Homeless program was established by the Stewart B. McKinney Assistance Act in 1988 and is administered by the Bureau of Health Care Delivery and Assistance in the U.S. Department of Health and Human Services. In its first year the program served more than 231,000 homeless people and had more than 783,000 encounters. Of the 109 programs that were funded, 55 volunteered information about their recipients. The data report that:

- Fifty-three percent of those served lived in emergency shelters.
- Approximately 40 percent of those served were children and their parents.
- 37,000 users were women of child-bearing age.
- Approximately 2,000 of the users were pregnant. Thirteen percent of the pregnant women were teenagers.
- 46,000 users had no resources to pay for health care.

These figures illustrate the alarming health care needs of the homeless. Additionally, the projects that reported expect to serve more than 550,000 homeless in the second year of operation. That number represents only half of the projects and does not take into account all the areas in the country that are in need of such projects. Increasingly, families and young children are found among the ranks of the homeless, presenting a formidable challenge.

What has caused this significant increase in homeless families? Probably the single largest cause is the lack of affordable housing. Federal support for housing has dropped from $28 billion in 1981 to $9 billion in 1986, essentially eliminating federal support for construction of low-income housing. In addition, nearly 500,000 low-income housing units are lost each year to development, condominium conversion, and abandonment.

The lack of housing, therefore, is the underlying reason but certainly not the only cause of homelessness. Several other factors have been identified that contribute to the incidence of homelessness. Domestic violence often contributes to residential instability. Health problems also can be a factor. Often a health problem creates a crisis leading to loss of employment, family disruption, financial problems, and finally, eviction. The problem of substance abuse is yet another reason for homelessness. Drug abuse and/or addiction drains the resources of families and contributes to family dysfunction and instability. Finally, difficulty obtaining and retaining stable income, diminished employment opportunities for families, and difficulties obtaining and retaining public assistance also contribute to homelessness.

Epidemiological studies of the homeless have been limited in accurately assessing the risk of homelessness on health. However, data from clinics funded by the Robert Wood Johnson project over the past four years do show an increased risk for health problems in users of the clinics who were homeless. For example, upper respiratory infections and ear infections were twice as common in homeless children under five years old than in ambulatory care children in general. Skin and gastrointestinal disorders occurred four times as often. Dental problems were ten times as great. In general, the rate of chronic disorders among homeless children is nearly twice that observed among all ambulatory children. Also, children living in a shelter or in a car, or moving from shelter to shelter, or from an apartment to a car to a shelter are subject to very unstable living situations. They have very few opportunities for play and development. They are at higher risk for neglect and abuse. Clearly, homelessness puts them at high risk for significant disabilities as they grow older.

In addition, homeless women who are pregnant exhibit conditions that put them at high risk. These conditions include chronic mental illness, substance abuse, tuberculosis, diabetes, anemia, and neurological problems. One study explored how pregnant women in New York City were affected by homelessness. This study compared the experiences of homeless women with those of the general population. The study found that the relative risk of receiving no prenatal care for residents of welfare hotels was twice that of women living in housing projects, and four times that of general New York residents. The risk of low birthweight and infant mortality was also higher among the homeless.

Other risk factors that contribute to the rates of low birthweight and infant mortality are especially prevalent among homeless women. For example, poor nutrition due to the erratic availability of food contributes to the risk of poor outcomes. In addition, little or no social support exists for homeless pregnant women in the majority of cases. Often, drugs are a factor.

However, the biggest challenge homeless pregnant women face is obtaining prenatal care. The reason is access. Given the problems of penetrating the system that all poor women face – problems getting prenatal appointments in overbooked public clinics, problems with Medicaid eligibility – homeless women are in even more difficult situations. Homeless women trying to get appointments must stand in long lines to use public telephones at shelters or go outside of the shelters to find

telephones. Transportation is also a significant barrier. For example, a shelter in West Los Angeles is a two-and-a-half-hour bus ride from the nearest public hospital.

Keeping a prenatal appointment often conflicts with what homeless people need to do in order to survive. For example, a woman might have to be at a shelter at a certain time in order to secure a bed. She may have to choose between putting her family in a shelter and keeping a prenatal appointment. This is also a problem with respect to getting meals. One solution to this problem could be setting up a meal program where women could also meet with doctors. A successful example of this approach has been set up in Los Angeles. It combines meals with a tuberculosis treatment program so people do not have to choose between the two.

Continuity-of-care problems also are significant for the homeless. Because of federal requirements, most shelter beds prohibit a person from staying more than thirty days. If a woman begins care at one facility, then is moved to a shelter fifty miles away, it is doubtful she will find transportation to keep her appointments. Another related problem is that medicines and vitamins cannot be stored. If they can be stored, they are often lost or stolen. Additionally, bed rest for these women is essentially impossible.

Yet several strategies have been identified to treat women living under these conditions. These strategies include:

- Building stronger links between the public health care system, departments of mental health, substance abuse treatment programs, and housing agencies so that referrals and follow-up treatments can be ensured.
- Providing health education for homeless people.
- Improving continuity of services for homeless families once they leave shelters, specifically for transitioning families out of homelessness into permanent housing.

Programs aimed at providing prenatal care to homeless women are being developed all around the country. A proposal has been submitted in Los Angeles to develop a model program involving transitional housing. This program will identify pregnant women who are homeless and place them in transitional housing. The women will stay in this housing for twelve to twenty-four months. There they will receive support services to hook them up with prenatal care. This support will continue during the course of pregnancy and for six to twelve months after the birth. A substance abuse outpatient treatment program is also being established to work hand in hand with this program.

However, programs like this are very expensive. More emphasis needs to be placed on preventing more people from falling out of the housing market. Expanded eligibility for Medicaid, reduction of the number of uninsured, and increased support for public hospitals and other publicly-supported health care providers can also do much to improve the health care needs of the homeless.

Conclusion

Homeless women and substance abusers are two very significant subpopulations of Medicaid-eligible pregnant women requiring special intervention. These women

are at increased risk for complicated pregnancies and births, as well as other health problems. Further, children born to these women often exhibit serious lifelong health problems, requiring extensive resources to treat. States are faced with an especially difficult challenge when designing effective programs that will successfully reach and treat these women.

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ENDNOTES

1. OBRA-89, passed in November 1989, mandates that all states expand eligibility to cover pregnant women and children up to the age of six living at or below 133 percent of the federal poverty level.

2. Medically Needy persons or families are those who possess too much income to qualify for Medicaid coverage. By incurring medical expenses, these persons can "spend down" or reduce their income to welfare levels and become eligible in states that have opted to pick up the "medically needy."

3. Since March 1989, Oregon has discovered that no quality control problems existed. Rather, there has been a lack of documentation. Therefore, the system has been tightened up slightly. The state now requires that verification of income be obtained and a five-day turnaround has been implemented (replacing the twenty-four-hour determination).

4. In February 1990, there were 469 physicians covered under the fund. Thus far, four suits have been either threatened or filed, all related to delivery/infant problems. Further, the state has recently witnessed private insurers extending a significant decrease in liability insurance premiums to providers covered under the fund.

5. The Budget Reconciliation Act of 1989 directs state Medicaid programs, beginning July 1, 1990, to notify pregnant women and children under age five who receive Medicaid of the availability of WIC benefits.

6. The Child Nutrition Bill passed in 1989 (P.L.101-147) reauthorized the WIC program. One provision of the bill allows state WIC agencies to implement new income eligibility guidelines at the same time the state implements income eligibility guidelines under the Medicaid program provided that the new guidelines are not implemented later than July 1 of each year.

7. While the 1989 Child Nutrition Bill does not change the manner in which the WIC program defines family size, the bill does stipulate that participation in Medicaid automatically satisfies the WIC income test. Also, any individual who is a member of a family in which a pregnant woman or infant receives Medicaid will be automatically income-eligible for WIC.

8. A large step was taken by Medicaid recently to cover uninsured children. OBRA-89 mandates that Medicaid cover all children up to age six living at or below 133 percent of the federal poverty line.

9. None of these specific proposals were adopted in 1989. See preceding endnote.

10. OBRA-89 legislation contains a provision that requires states to provide coverage for treatment to correct physical or mental problems identified during EPSDT screenings, even if these follow-up services are not covered under the state's Medicaid plan.

RELATED HEALTH POLICY PUBLICATIONS AVAILABLE FROM THE NATIONAL GOVERNORS' ASSOCIATION

Improving State Programs for Pregnant Women and Children: Conference Proceedings is one of a series of publications on state perinatal program issues published by the Health Programs unit within NGA's Center for Policy Research. Other recent publications addressing state perinatal program issues include:

Reaching Women Who Need Prenatal Care: Strategies for Improving State Perinatal Programs by Ian T. Hill. June 1988. $15.00.

Since early 1987, a majority of states have implemented expanded Medicaid programs for pregnant women and young children living in poverty. In order to improve these populations' access to early and appropriate prenatal care, this book describes how numerous states are also reshaping and enhancing their systems for eligibility and outreach. Extensive discussion of presumptive eligibility is included.

Estimating Medicaid Eligible Pregnant Women and Children Living Below 185 Percent of Poverty: Strategies for Improving State Perinatal Programs by Paul W. Newacheck. June 1988. $15.00.

A companion document to the previous year's report, this volume projects, by state, potential eligibles under OBRA-87 in families with income below 185 percent of poverty.

Increasing Provider Participation: Strategies for Improving State Perinatal Programs by Deborah Lewis-Idema. July 1988. $15.00.

Assuring adequate provider participation has been a perennial concern for Medicaid, Maternal and Child Health, and other programs for low-income pregnant women and children. This document describes the scope of the problem and provides new insights into strategies states are employing to expand provider participation in public perinatal programs.

Coordinating Prenatal Care: Strategies for Improving State Perinatal Programs by Ian T. Hill and Janine Breyel. July 1989. $15.00.

To complement state efforts to expand Medicaid eligibility for low-income pregnant women and children, states are also beginning to initiate reforms in their service delivery systems. In an effort to improve recipient access to diverse services and overall continuity of care, nearly half of the states have implemented programs of prenatal care coordination or case management. This report details the component parts of these systems and reports on initial positive experiences.

Enhancing the Scope of Prenatal Services: Strategies for Improving State Perinatal Programs by Trude Bennett and Ian T. Hill. July 1989. $15.00.

In an effort to improve the health status of mothers and children and improve birth outcomes, nearly half the states have significantly expanded the types of prenatal care services they provide under Medicaid. Building in nontraditional "support" services such as comprehensive risk assessments, nutritional counseling, psychosocial counseling, and health education, states are actively attempting to increase the efficacy of their prenatal care initiatives.

Designing Program Evaluations: Strategies for Improving State Perinatal Programs by Linda T. Bilheimer. July 1989. $15.00.

Measuring the impact of efforts to improve maternal and child health remains a critical challenge to all states implementing perinatal initiatives. This report discusses the broad range of methodological and data constraints states face when attempting to conduct program evaluations.

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